DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

June 5, 2012

Sally Jeffcoat, President and CEO
St. Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

CMS Certification Number: 13-0007

Re: Complaint survey 05/01/2012 and CoPs not met
Deemed status removed and placed under State survey jurisdiction
Full health and life safety code survey to be conducted

Dear Ms. Jeffcoat:

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation (CoP) established by the Secretary of Health and Human Services.

The Idaho Bureau of Facility Standards (State agency) completed a complaint investigation authorized by the Centers for Medicare & Medicaid Services (CMS) on May 1, 2012. Based on a review of the deficiencies identified during this investigation, we have determined that St. Alphonsus Regional Medical Center **is not in substantial compliance** with the following Medicare hospital Conditions of Participation (CoP):

- 42 CFR § 482.13 – Patient Rights,
- 42 CFR § 482.24 – Medical Record Services, and
- 42 CFR § 482.43 – Discharge Planning.

Section 1865 of the Social Security Act (The Act) and pursuant regulations provide that a hospital accredited by The Joint Commission will be "deemed" to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of The Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency which would, if found to be present, adversely affect the health and safety of patients. Therefore, as a result of the May 1, 2012, complaint survey findings, we are required following timely notification to the accrediting body, to place the hospital under Medicare State agency survey jurisdiction until the hospital is in compliance with all Conditions of Participation.

The deficiencies cited limit the capacity of St. Alphonsus Regional Medical Center to furnish services of an adequate level or quality. The deficiencies, which led to our decision, are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). It is not a requirement to submit a plan of correction; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable if requested.

You may therefore wish to submit your plans for correcting the deficiencies cited within 10 calendar days of receipt of this letter. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Each deficiency should be corrected as soon as possible. Additionally, please sign and date page one where indicated prior to returning the CMS-2567 to our office. Please send the completed plan of correction to the address below, with a copy to the State agency:

CMS – Survey and Certification
Attention: Kate Mitchell
2201 Sixth Avenue, RX-48
Seattle, WA 98121
Fax: (206) 615-2088

Additionally, in accordance with § 1865(b) of The Act, the Idaho Bureau of Facility Standards, will conduct a full unannounced health and life safety code survey of your hospital to assess compliance with all the Medicare Conditions of Participation, within the next 60 days.

The recommendation that St. Alphonsus Regional Medical Center submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When St. Alphonsus Regional Medical Center has been found to meet all the Medicare Conditions of Participation for hospitals, the State agency will discontinue its survey jurisdiction.

Under CMS regulations 42 CFR § 498.3(d), this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Copies of this letter are being provided to the State agency and The Joint Commission. You can also pursue any concerns you may have with The Joint Commission at any time.

If you have any questions, please contact Kate Mitchell of my staff at (206) 615-2432 or e-mail Catherine.mitchell@cms.hhs.gov .

Sincerely,

Kate Mitchell

for Jerilyn McClain, RN, MPH
Survey, Certification and Enforcement Branch Manager

Enclosure

cc: Idaho Bureau of Facility Standards
The Joint Commission

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

June 5, 2012

Sally Jeffcoat, Administrator
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

RE: St Alphonsus Regional Medical Center, Provider #130007

Dear Ms. Jeffcoat:

This is to advise you of the findings of the complaint survey at St Alphonsus Regional Medical Center, which was concluded on May 1, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by

June 18, 2012, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm
Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

July 6, 2012

Aline Lee, RN
Director of Patient Safety and Regulatory Compliance
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83704

CMS Certification Number: 13-0007

Re: Plan of correction received

Dear Ms. Lee:

The Centers for Medicare and Medicaid Services (CMS) is in receipt of St Alphonsus Regional Medical Center's voluntarily-submitted plan of correction in response to the complaint survey completed May 1, 2012, by the Idaho Bureau of Facility Standards (State survey agency). I understand that the State survey agency also contacted you and provided informal feedback on the plan of correction. As per our June 5, 2012 letter, an unannounced full health and life safety code survey will be conducted by the Idaho Bureau of Facility Standards.

If you have any questions, please contact me at (206) 615-2432 or by e-mail catherine.mitchell@cms.hhs.gov .

Sincerely,

Kate Mitchell, RN, Health Insurance Specialist
Survey, Certification and Enforcement Branch

cc: Idaho Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130007	A. BUILDING _____ B. WING _____	C 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTER	1055 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS	A 000	Please see enclosed plan of correction.	

The following deficiencies were cited during the complaint investigation survey of your hospital. The surveyors conducting the investigation were:

Gary Guiles RN, HFS, Team Leader
Rebecca Lara RN, BA, HFS

The following acronyms were used in this report:

ADLs = Activities of Daily Living
ALF = Assisted Living Facility
Appt = appointment
CHF = congestive heart failure
CRM = Clinical Resource Manager
DC = discharge
DC'd = Discontinued
DPSRC = Director of Patient Safety and Regulatory Compliance
DTs = Delirium Tremens, a severe form of alcohol withdrawal that involves sudden and severe mental or nervous system changes
ED = Emergency Department
EMR = Electronic Medical Record
ER = Emergency Room
Eval = Evaluation
H&P = "History and Physical"
ICU = Intensive Care Unit
IDCP = Interdisciplinary Care Plan
IM = Intramuscular
I&O = Intake and Output
IPOC = Interdisciplinary Plan of Care
IV = Intravenous
LIP = Licensed Independent Practitioner
LMSW = Licensed Medical Social Worker
LOC = Level of Consciousness
MD = Medical Doctor
MED MGMT = Medication Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sally E Jaffus	CEO	6/18/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 MSW = Masters in Social Work NG = Nasogastric POA = Power of Attorney POC = Plan of Care pt = Patient PT = Physical Therapy RAC = Regulatory Accreditation Coordinator ROM = Range of Motion RN = Registered Nurse R/T = Related To VTE = venous thromoembolism (blood clot) X = times	A 000		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on staff interviews and review of medical records and hospital policies and review of grievances, it was determined the hospital failed to protect and promote patients' rights. This prevented the hospital from processing all grievances, compromised the hospital's ability to keep patients safe, and prevented staff from utilizing restraints in a consistent manner. Findings include: 1. Refer to A164 as it relates to the facility's failure to ensure restraints were used only when less restrictive interventions were determined to be ineffective to protect the patient, staff or others from harm. 2. Refer to A166 as it relates to the facility's failure to ensure patients' plans of care were modified in writing to reflect the use of restraints.	A 115		

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A 115	Continued From page 2 3. Refer to A168 as it relates to the facility's failure to ensure restraints were used only in accordance with the order of a physician or LIP and LIPs ordering restraints were authorized to do so by hospital policy in accordance with State law. 4. Refer to A174 as it relates to the facility's failure to ensure restraints were discontinued at the earliest possible time. 5. Refer to A185 as it relates to the facility's failure to ensure documentation in patients' medical records contained a detailed description of the patient's behavior during the time of restraints and patients' response to interventions used. 6. Refer to A187 as it relates to the facility's failure to ensure documentation of patients' conditions or symptoms that warranted the use of restraints. 7. Refer to A188 as it relates to the facility's failure to ensure patients' response to the intervention used, including the rationale for continued use of the intervention (restraints) was documented. The cumulative effect of these negative systemic practices resulted in the inability of the hospital to promote and protect the rights of patients.	A 115		
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient,	A 164		

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A 164	Continued From page 3 a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure 4 of 6 patients (# 1, #2, #3, and #4), who were physically restrained, were restrained only after a comprehensive assessment was performed and less restrictive interventions were determined to be ineffective. This resulted in the potential for unnecessary use of restraints. Findings include: 1. Patient #1's medical record documented a 47 year old female admitted to the facility on 1/30/12 for altered mental status and alcohol detoxification. Patient #1 presented to the ED on 1/30/12 at 9:49 AM. She was transferred to an inpatient unit some time after 1:59 PM as an "Emergency Room Progress Note" documented she was in the ED at that time. The medical record contained conflicting information as to whether Patient #1 was discharged on 2/09/12 or 2/10/12. Patient #1 was restrained without clear evidence less restrictive alternatives had been attempted and found to be ineffective. Examples include: 1/30/12: An "Emergency Room Progress Note," written by an RN at 12:44 PM on 1/30/12, stated Patient #1 was "...placed in posey due to multiple attempts to get out of bed and pulling on lines." (Posey is a company that makes numerous types of soft and hard restraints.) The types of restraint(s) used were not specified. The use of less restrictive interventions prior to the application of restraints was not documented. No other nursing	A 164		

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A 164	Continued From page 4 notes related to restraints were documented in the ED. The "Direct Charting Flowsheet," dated 1/30/12 at 3:35 PM, called for a nursing "Adult Admission Assessment" to be completed. This was likely the time Patient #1 arrived on the inpatient unit. The time of arrival was not documented. Restraints were not mentioned in the assessment. The first physician order for restraints was dated 1/30/12 at 5:12 PM. The order was for 4 side rails up on Patient #1's bed and bilateral wrist restraints. The order stated "Alternatives tried: Increased observation." The documentation did not state what "Increased observation" meant or indicate other interventions attempted prior to the use of restraints. Following the "Emergency Room Progress Note," noted above, the first nursing documentation that mentioned Patient #1's restraints was a nursing "Restraint Non-Violent Form" dated 1/30/12 at 6:00 PM (entered at 6:55 PM). The note stated Patient #1 had bilateral wrist restraints applied and all side rails were up. The note documented "Alternatives to restraints attempted: Bed alarm, Covered exposed lines/tubes, Decreased environmental stimuli, Increased observation." The note did not state if the bed alarm was applied in the ED or on the inpatient unit. It did not describe Patient #1's response to the alarm and why it was ineffective (e.g. Patient #1 ignored the alarm, the alarm was not consistently activated and/or heard by staff). The note did not describe what the terms "Covered exposed lines/tubes, Decreased environmental stimuli,	A 164		

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A 164	Continued From page 5 Increased observation" meant. Additionally, Patient #1's response to the interventions and whether they were used alone or if one or more were used simultaneously was not documented. An assessment which demonstrated less restrictive alternatives were tried and were ineffective prior to the use of the side rails, wrist, and posey restraints was not documented. 2/07/12: A physician order for a vest restraint for Patient #1 was dated 2/07/12 at 2:42 AM. It stated "Alternatives tried: Bed Alarm." It did not state the response to the bed alarm or how it was ineffective. A subsequent nursing "Restraint Non-Violent Form," completed at 4:00 AM on 2/07/12, stated a vest restraint was applied to Patient #1. The nursing note stated Patient #1 was restrained for "Unable to follow instructions and attempts to discontinue equipment." It also indicated Patient #1 was "Unable to maintain balance/ambulate unassisted and refuses/is unable to ask for assistance." The note stated "Alternatives to Restraints Attempted: Bed alarm, Decreased environmental stimuli, Increased observation, Re-oriented." The "Restraint Non-Violent Form" did not state what specific behaviors the restraint was attempting to prevent. The terms "Decreased environmental stimuli" and "Increased observation" were not defined. The documentation did not indicate if the interventions had been used simultaneously, in combination, or alone. The corresponding 2/07/12 at 2:42 AM physician's order indicated "Alternatives tried: Bed Alarm." It could not be determined when the	A 164		

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A 164	Continued From page 6 additional interventions had been used, as the bed alarm was the only alternative documented in the order. The RAC, interviewed on 4/24/12 beginning at 12:30 PM, confirmed the documentation for Patient #1. She stated the use of less restrictive measures and their results were not clearly documented. The hospital did not determine that the use of less restrictive measures were ineffective prior to utilizing restraints for Patient #1. 2. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. He was admitted for combative behavior. A physician order, dated 3/30/12 at 5:26 PM, called for "Restraint: Soft Limb X4 [wrists and ankles]." The order stated "Alternatives Tried: 1:1 intervention." The order did not state how the 1:1 intervention had been ineffective. Other less restrictive interventions attempted were not documented. A nursing "Restraint Non-Violent Form," dated 3/30/12 at 6:00 PM (34 minutes after the order was received), indicated Patient #3 was not restrained at that time. A nursing "Restraint Non-Violent Form," dated 3/30/12 at 8:00 PM, stated Patient #3 was "Resisting restraints." The note did not state what time restraints were applied or the type of restraints in use. The note	A 164		

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A 164	Continued From page 7 stated "Alternatives to Restraints Attempted: Bed Alarm." Additionally, the note did not indicate other less restrictive measures attempted prior to the use of restraints. The RAC, interviewed on 4/25/12 beginning at 11:10 AM, confirmed the documentation for Patient #3. She stated the use of less restrictive measures and their results were not clearly documented. The hospital did not determine that the use of less restrictive measures were ineffective prior to utilizing restraints for Patient #3. 3. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 with primary diagnoses of alcoholism with alcohol withdrawal. He was discharged on 2/20/12. A physician's "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment of symptoms related to alcohol withdrawal. A physician's "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor for continued treatment. The initial nursing "Restraint Non-Violent Form", dated 2/06/12 at 4:00 AM documented "Alternatives to Restraints Attempted - Covered exposed lines/tubes". The documentation did not include Patient #2's response to the covering of the exposed lines/tubes. No other less restrictive alternatives were documented as being attempted.	A 164		

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A 164	Continued From page 8 A physician's order, dated 2/06/12 at 5:19 AM, initiated soft restraints to Patient #2's wrists and ankles. The order documented "Alternatives tried: Covered exposed lines/tubes" as an alternative to restraints. The documentation did not state what "covered exposed lines/tubes" meant or state why the intervention had been unsuccessful. No other less restrictive alternatives were documented as having been attempted. A physician's order, dated 2/14/12 at 1:34 PM, called for a restraint vest and soft restraints to Patient #2's wrists and ankles. The order documented "Alternatives Tried: 1:1 Intervention" as an alternative to restraints. The response to 1:1 intervention as an alternative was not documented. The nursing "Restraint Non-Violent Form," dated 2/14/12 at 12:00 PM, documented "Chair alarm" as an alternative to Patient #2's restraints. It did not document Patient #2's response to the chair alarm or other less restrictive interventions attempted. The RAC, interviewed on 4/26/12 beginning at 8:00 AM, confirmed the documentation for Patient #2. She stated the use of less restrictive measures and their results were not clearly documented. The hospital did not ensure less restrictive alternatives to restraints were attempted and found to be ineffective for Patient #2. 4. Patient #4's medical record documented she was an 82 year old female who was admitted to	A 164		

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A 164	Continued From page 9 the facility on 2/04/12 and discharged on 2/08/12. According to a "History and Physical" dated 2/04/12 at 5:30 PM, Patient #4 was admitted for care related to increased confusion and agitation. There was also a documented history of dementia and psychosis. A physician's order, dated 2/04/12 at 2:38 PM, called for 4 soft limb restraints to wrists and ankles. The order documented "Alternatives tried: 1:1 intervention." The order did not document Patient #4's response to 1:1 intervention. Additionally, other less restrictive interventions were not documented as attempted. A subsequent nursing "Restraint Non-Violent Form", dated 2/04/12 at 3:45 PM, did not include 1:1 intervention as an alternative to restraints. A second nursing "Restraint Non-Violent Form", dated 2/04/12 at 6:00 AM, did not document 1:1 intervention as an alternative to restraints. It documented "Bed alarm, Decreased environmental stimuli, Limited distractions" as the alternatives to restraints. The form did not explain what these terms meant. The form did not document Patient #4's response to these measures. The documentation did not indicate if the interventions had been used simultaneously, in combination, or alone. It could not be determined when these interventions had been attempted, as the preceding physician order (2/04/12 at 2:38 PM) called for restraints. The use of alternative interventions would indicate the patient had been released from restraints. In which case, another physician order would be required; none was present. The RAC, interviewed on 4/26/12 beginning at	A 164		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 164	Continued From page 10 12:50 PM, confirmed the documentation for Patient #4. She stated the use of less restrictive measures and their results were not clearly documented. The hospital did not ensure less restrictive alternatives to restraints were consistently attempted and ineffective for Patient #4.	A 164		
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and hospital policies, it was determined the hospital failed to ensure the use of physical restraints was incorporated into patients' plans of care for 6 of 6 patients (#1, #2, #3, #4, #5, and #6), who were physically restrained. This resulted in patients being restrained without clear and consistent direction to staff regarding the care of patients in restraints. Findings include: 1. The policy "Restraint and Seclusion," dated 12/06/11, stated at section III.E. "Plan of care updated in accordance with the needs of the patient following assessment and evaluation." The policy did not direct staff as to how this should occur. The RAC, interviewed on 4/26/12 beginning at 10:15 AM, stated interventions related to restraints, such as releasing the patient at least every 2 hours and providing care, were not listed in the POC. She stated staff interventions were	A 166		

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	130007	A. BUILDING _____ B. WING _____	C 05/01/2012

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A 166	Continued From page 11 listed in the restraint policy and staff was expected to follow them. She stated POCs related to restraints were not individualized. 2. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 with primary diagnoses of alcoholism with alcohol withdrawal. He was discharged on 2/20/12. A physician's "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment of symptoms related to alcohol withdrawal. A physician's "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor for continued treatment. A physician's order, dated 2/06/12 at 5:19 AM, initiated soft restraints to both ankles and wrists. Another physician's order, dated 2/07/12 at 6:42 PM, called for the use of a restraint vest in addition to the wrist and ankle restraints. Hand mitts were also ordered on 2/08/12 at 10:07 AM. The nursing "Restraint Non-Violent Form", completed on 2/11/12 at 8:00 AM, stated Patient #2 remained in 4 point soft ankle and wrist restraints and had mitts applied to both hands. All non-violent restraints were discontinued on 2/16/12 at 4:00 PM according to the "Restraint Non-Violent Form." The "Care Plan" for Patient #2 was initiated on 2/06/12 and maintained through discharge on 2/20/12. Patient #2's plan of care did not reflect the use of restraints. The RAC was interviewed on 4/26/12 beginning	A 166		

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A 166	Continued From page 12 at 12:50 PM. She confirmed the plan of care did not document the changing needs of the patient related to the on-going use of non-violent medical restraints. The hospital did not ensure Patient #2's POC was modified to include restraints. 3. Patient #4's medical record documented an 82 year old female admitted to the facility on 2/04/12 for care related to increased confusion and agitation and a related history of dementia and psychosis. She was discharged on 2/08/12. A physician's order, dated 2/04/12 at 2:38 PM, called for the use of soft restraints to both wrists and ankles. According to a nursing "Restraint Non-Violent Forms," Patient #4 remained in non-violent medical restraints until 2/07/12 at 8:00 AM, when restraints were discontinued. The "Care Plan" for Patient #4 was initiated on 2/04/12 and maintained through discharge on 2/08/12. The plan of care did not reflect the use of restraints. The RAC was interviewed on 4/26/12 beginning at 12:50 PM. She reviewed the record and confirmed the care plan did not document the on-going use of non-violent medical restraints. Patient #4 was physically restrained without an update being made to her POC to reflect restraints. 4. Patient #5's medical record documented a 74 year old male who was admitted to the facility on 4/06/12 for care related to sub-acute delirium or	A 166		

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A 166	Continued From page 13 increased confusion, hallucinations and disordered thinking. He was discharged on 4/13/12. A physician's order, dated 4/08/12 at 4:41 PM, initiated the use of soft restraints to Patient #5's wrists and ankles. Another order, dated 4/08/12 at 4:57 PM, and immediately following the order for soft ankle and wrist restraints, documented the same restraints with the addition of "Restraint: Vest." The nursing "Restraint Non-Violent Form," dated 4/10/12 at 1:00 PM, stated Patient #5's restraints were discontinued. The "Care Plan" for Patient #5 was initiated on 4/06/12 at 5:58 PM and maintained through discharge on 4/13/12. However, the care plan did not reflect the use of restraints. The RAC was interviewed on 4/26/12 beginning at 12:50 PM. She confirmed the care plan did not document the changing needs of the patient related to the on-going use of non-violent medical restraints. Patient #5's POC was not modified to include the use of physical restraints. 5. Patient #6's medical record documented a 57 year old woman who was admitted to the hospital on 4/17/12 and remained a patient on the orthopedic/joint unit at the time of the survey. Patient #6 was admitted for care related to mild encephalopathy (brain dysfunction syndrome) attributed to low-grade sepsis (whole body inflammatory state) and/or electrolyte imbalance. A physician ordered soft bilateral wrist restraints	A 166		

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A 166	Continued From page 14 for Patient #6 on 4/19/12 at 2:48 AM. The nursing "Restraint Non-Violent Form," dated 4/22/12 at 12:00 AM, indicated she was in restraints until this time. The POC for Patient #6 was initiated on 4/17/12 at 9:32 PM. The care plan was not updated to reflect the use of restraints. The RAC was interviewed on 4/30/12 beginning at 9:50 AM. She confirmed the care plan did not document the changing needs of the patient related to the on-going use of non-violent medical restraints. The hospital did not ensure Patient #6's POC was modified to include the use of restraints. 6. Patient #1's medical record documented a 47 year old female who was admitted to the hospital on 1/30/12 for altered mental status and alcohol detoxification. The medical record contained conflicting information as to whether Patient #1 was discharged on 2/09/12 or 2/10/12. The nursing "Restraint Non-Violent Forms" documented Patient #1 was restrained with wrist restraints from 1/30/12 at 6:00 PM to 2/05/12 at 2:00 PM. Patient #1's "Care Plans," initiated on 1/30/12 and completed on 2/09/12, listed "Restraint Orders" and stated they were "Completed." The plan did not include the type of restraints used, reason and goal for the use of the restraints, or how/when monitoring was to occur to ensure Patient #1's care, comfort, and medical needs were met. Under the section labeled	A 166		

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A 166	Continued From page 15 "Environmental Safety Measures," the plan listed "Side rails up X4 of 4" but this was not listed as a restraint. The plan did not reflect an assessment, reason, goal, or monitoring related to the use of all four side rails up on Patient #1's bed. The RAC, interviewed on 4/24/12 beginning at 12:30 PM, confirmed the documentation for Patient #1. The RAC stated the POC did not address restraints. Patient #1's POC was not modified to include the use of restraints. 7. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. Nursing "Restraint Non-Violent Forms" documented Patient #3 was restrained from 3/30/12 at 8:00 PM until 4/06/12 at 8:00 AM. Patient #3's "Care Plans," initiated on 3/12/12 and continued through 4/24/12 did not mention restraints or provide direction to staff in relation to restraints. The RAC, interviewed on 4/25/12 beginning at 11:10 AM, confirmed the documentation for Patient #3. The RAC stated the POC did not include restraints. The hospital did not ensure nursing staff modified Patient #3's POC to include restraints.	A 166		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT	A 168		

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A 168	Continued From page 16 OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the facility failed to ensure physician orders were consistently obtained and followed for the use restraints for 6 of 6 patients (#1, #2, #3, #4, #5, and #6) for whom restraints were used. This resulted in patients being subjected to physical restraint without an appropriate order. Findings include: 1. Patient #1's medical record documented a 47 year old female admitted to the facility on 1/30/12. According to the "History and Physical" dated 1/30/12 at 6:20 PM, Patient #1 was admitted through the ED for care related to alcohol detoxification secondary to substance abuse. The medical record contained conflicting information as to whether Patient #1 was discharged on 2/09/12 or 2/10/12. An "Emergency Room Progress Note," written by an RN at 12:44 PM on 1/30/12, stated Patient #1 was "...placed in posey due to multiple attempts to get out of bed and pulling on lines." (Posey is a company that makes numerous types of soft and hard restraints.) The type of restraint(s) used was not specified. No other nursing notes related to restraints were documented until a "Restraint	A 168		

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A 168	Continued From page 17 Non-Violent Form," which was dated 1/30/12 at 6:00 PM. The form indicated it was a "Restraint Initiation Assessment." It stated the type of restraints were "All side rails up, soft limb X 2, Wrists, bilateral." A physician order for the restraints applied at 12:44 PM on 1/30/12 was not documented. The first order for restraints was dated 1/30/12 at 5:11 PM. The RAC, interviewed on 4/24/12 beginning at 12:30 PM, confirmed the documentation for Patient #1. The RAC confirmed restraints were applied to Patient #1 at 12:44 PM on 1/30/12. She stated an order to apply the restraints was not documented. Restraints for Patient #1 were not used in accordance with a physician order. 2. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. The note stated he had come from a nursing home after increased aggression and striking a nurse in the abdomen. The note stated Patient #3 was calm at first but "...became aggressive with the staff, was trying to leave, and actually required restraint and chemical sedation." "Emergency Room Progress Notes" by an RN at 6:41 PM, stated Patient #3 was walking in hallways and other patients' rooms. He became verbally aggressive and was placed in wrist restraints from 6:42 PM - 9:15 PM. An order for the wrist restraints was not	A 168		

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A 168	Continued From page 18 present in the medical record. The RAC was interviewed on 4/26/12 beginning at 10:00 AM. She confirmed the order for restraint was not documented. Restraints for Patient #3 were not used in accordance with a physician order. 3. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 and was discharged on 2/20/12. According to the "History and Physical," Patient #2's primary diagnosis was alcoholism with alcohol withdrawal. A physician's order, dated 2/06/12 at 5:19 AM, initiated non-violent, medical restraints for Patient #2, and stated "Soft Limb X 4 " . Nursing "Restraint Non-Violent Forms" documented Patient #2 was in restraints until 2/16/12 at 4:00 PM. No orders to continue soft 4 point restraints for Patient #2 were documented for the dates of 2/11/12 or 2/15/12. The RAC was interviewed on 4/26/12 at 8:00 AM. She reviewed the record and confirmed the documentation in Patient #2's medical record did not explain the order discrepancies. The facility failed to consistently obtain orders for restraints applied to Patient #2. 4. Patient #4's medical record documented an 82 year old female admitted to the facility on 2/04/12 for care related to increased confusion and agitation and a related history of dementia and psychosis. She was discharged on 2/08/12.	A 168		

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A 168	Continued From page 19 A physician's order, dated 2/04/12 at 2:38 PM, called for the use of soft restraints to both wrists and ankles "To Ensure Patient Safety." The order indicated Patient #4 could be released when she was no longer attempting to harm others. A "Restraint Non-Violent Form," was completed by the RN on 2/04/12 at 3:45 PM. The RN indicated Patient #4 was in soft limb restraints X2 and a "Vest (modified)." The medical record did not contain a physician's order for the use of a vest restraint on 2/04/12 at 3:45 PM. The RAC reviewed Patient #4's medical record on 4/26/12 at 12:50 PM. She confirmed that a physician's order for the vest restraint was not documented. Restraints for Patient #4 were not used in accordance with a physician order. 5. Patient #5's medical record documented a 74 year old male admitted to the facility on 4/06/12 for care related to subacute delirium, or increased confusion, hallucinations and disordered thinking. He was discharged on 4/13/12. A physician's order, dated 4/10/12 at 8:12 AM, initiated soft restraints to bilateral wrists and ankles. The order indicated the reason for the restraints was "Harmful to Self." A "Restraint Non-Violent Form" was completed by the RN on 4/10/12 at 8:00 AM. The RN indicated Patient #5's wrists and ankles were restrained and he was placed in a "Vest." The medical record did not contain a physician's order for the vest restraint.	A 168		

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A 168	Continued From page 20 The RAC reviewed Patient #5's record on 4/26/12 beginning at 12:50 PM. She confirmed that an order for the vest restraint documented on 4/10/12 at 8:00 AM was not found in the record. Restraints for Patient #5 were not used in accordance with a physician order. 6. Patient #6's medical record documented a 57 year old woman admitted to the hospital on 4/17/12 and remained a patient on the orthopedic/joint unit at the time of the survey. Patient #6 was admitted for care related to mild encephalopathy (brain dysfunction syndrome) attributed to low-grade sepsis (whole body inflammatory state) and/or electrolyte imbalance. A physician's order, dated 4/19/12 at 2:48 PM, stated "Restraint: Soft limb X 2." No documentation was present in the medical record that this order was carried out. The initial "Restraint Non-Violent Form," completed by the RN on 4/19/12 at 11:00 PM, stated 1 soft limb restraint was placed on Patient #6's right arm. The medical record did not contain a physician's order for this restraint. The RAC was interviewed on 4/30/12 at 9:30 AM. She reviewed Patient #6's medical record and confirmed the order for initiation of restraint on 4/19/12 at 11:00 PM was not present. Restraints for Patient #6 were not used in accordance with a physician's orders.	A 168		
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 174		

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A 174	Continued From page 21 Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure restraints were discontinued at the earliest possible time for 5 of 6 sample patients (#1, #2, #3, #4, and #6) who were physically restrained. This resulted in the potential for patients being restrained longer than necessary. Findings include: 1. Patient #1's medical record documented a 47 year old female admitted to the facility on 1/30/12. According to the "History and Physical", dated 1/30/12 at 6:20 PM, Patient #1 was admitted through the ED for care related to alcohol detoxification secondary to substance abuse. The medical record contained conflicting information as to whether Patient #1 was discharged on 2/09/12 or 2/10/12. "Restraint Non-Violent Forms" documented restraint usage every 2 hours between 1/30/12 at 6:00 PM and 2/05/12 at 2:00 PM when they were discontinued. The initial note, dated 1/30/12 at 6:00 PM, stated Patient #1 was placed in bilateral wrist restraints with all 4 side rails up on her bed. After the initial note, the type of restraint used was not documented again, even though the restraint orders changed. The order on 1/31/12 at 4:45 PM, stated "Restraint: Soft Limb X 4." The order on 2/01/12 at 5:25 PM, stated "Restraint: Soft Limb X 2." The order on 2/02/12 at 11:55 AM, stated "Restraint: Soft Limb X 4."	A 174		

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A 174	Continued From page 22 The order on 2/04/12 at 10:16 AM, stated "Restraint: Soft Limb X 2." Between 1/30/12 at 6:00 PM to 2/05/12 at 2:00 PM, "Restraint Non-Violent Forms" documented every 2 hours that "RN Eval for Discontinuing Restraint: Behavior for restraining continues." The only exception to this occurred on 2/04/12 at 4:00 AM when the nurse documented "Sleeping and unable to evaluate cooperation" and on 2/04/12 at 6:00 AM when the nurse documented "Meeting criteria for discontinuing restraint." (The restraints were not discontinued at this time.) During the time Patient #1 was restrained, "Restraint Non-Violent Forms" did not include documentation of specific behaviors that indicated a need for continued restraint. "Direct Charting Flowsheets" were used to document a variety of nursing assessment items such as vital signs, skin assessments, neurological assessments, IV assessments, behavior assessments, and other items. "Direct Charting Flowsheets" documented Patient #1 was either calm or sleeping 17 times between 1/30/12 at 6:00 PM to 2/05/12 at 2:00 PM. During this time, "Direct Charting Flowsheets" documented Patient #1 was agitated 5 times. The last documented time Patient #1 was agitated was on 2/03/12 at 8:00 PM. No "Direct Charting Flowsheet" described specific behavior that indicated Patient #1 required continued restraint. The RAC, interviewed on 4/24/12 beginning at 12:30 PM, confirmed the documentation for Patient #1. She stated she could not find documentation of specific behavior that indicated Patient #1 required continued restraint.	A 174		

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A 174	Continued From page 23 The hospital did not discontinue restraint to Patient #1 at the earliest time. 2. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. Diagnoses included schizophrenia and dementia. Nursing "Restraint Non-Violent Forms" documented Patient #1 was restrained from 3/30/12 at 8:00 PM through 4/06/12 at 8:00 AM. During that time, "Restraint Non-Violent Forms" documented every 2 hours that "RN Eval for Discontinuing Restraint: Behavior for restraining continues." The only exception to this occurred on 3/30/12 at 10:00 PM and 3/31/12 at 12:00 AM and 2:00 AM when Restraint Non-Violent Forms" documented "RN Eval for Discontinuing Restraint: Sleeping and unable to evaluate cooperation." No specific behaviors indicating that Patient #3 required restraint during this time were documented in the "Restraint Non-Violent Forms." "Direct Charting Flowsheets" documented Patient #3 was either calm or sleeping 31 times between 3/30/12 at 8:00 PM through 4/06/12 at 8:00 AM. During this time, "Direct Charting Flowsheets" documented Patient #3 was agitated only 1 time. During this time, Patient #3 did not have any tubes or lines that needed protection. Also, during this time, no "Direct Charting Flowsheet" documented Patient #1 exhibited specific behaviors that required restraint. The RAC was interviewed on 4/26/12 beginning	A 174		

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A 174	Continued From page 24 at 10:00 AM. She confirmed specific documentation indicating the need for restraint was not present in Patient #3's medical record. The hospital did not discontinue restraint to Patient #3 at the earliest time. 3. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 with primary diagnoses of alcoholism with alcohol withdrawal. He was discharged on 2/20/12. A "History and Physicial," dated 2/06/12 at 4:15 AM, stated Patient #2 was intubated in the ED. A physician's "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment. A physician "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor. A physician's order, dated 2/06/12 at 5:19 AM, initiated soft restraints to both ankles and wrists. A "Critical Care Progress Note," dated 2/11/12 at 7:11 AM, documented Patient #2 was extubated on 2/07/12. A physician "Progress Note," dated 2/13/12 at 10:27 AM, documented Patient #2 removed his NG tube and Foley catheter. These were not replaced. A physician's order, dated 2/13/12 at 4:03 PM, called for ankle and wrist restraints and a vest restraint. The order stated "Justification: To Ensure Patient Safety." An assessment of the need for continued restraint was not documented by the physician. The nursing Restraint Non-Violent Form," dated 2/14/12 at 4:00 PM did not document the reason for restraint. An assessment of Patient #2's need for continued restraint was not documented.	A 174		

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A 174	Continued From page 25 The "Restraint Non-Violent Form" documented restraint usage every 2 hours between 2/06/12 at 4:00 AM and 2/16/12 at 4:00 PM when they were discontinued. The initial note, dated 2/06/12 at 4:00 AM, stated Patient #2 was placed in bilateral ankle and wrist restraints. Between 2/06/12 at 4:00 AM and 2/16/12 at 4:00 PM, "Restraint Non-Violent Form" assessments were completed by nursing staff every 2 hours (except for a 6 hour period of time on 2/12/12 between 12:00 AM and 6:00 AM when nothing was charted) and contained documentation indicating "Behavior for restraining continues." During this time that Patient #2 was restrained, the "Restraint Non-Violent Form" did not include specific documentation as to why he needed continued restraint. The RAC, interviewed on 4/26/12 beginning at 8:00 AM, confirmed the documentation lacked the specific behaviors that indicated Patient #2 required continued restraint. The facility failed to ensure Patient #2's restraints were discontinued at the earliest possible time. 4. Patient #4's medical record documented an 82 year old female admitted to the facility on 2/04/12 for care related to increased confusion and agitation and a related history of dementia and psychosis. She was discharged on 2/08/12. A physician's order, dated 2/04/12 at 2:38 PM, called for the use of soft restraints to both wrists and ankles. The order indicated Patient #4 could be released when she was no longer attempting	A 174		

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A 174	Continued From page 26 to harm others. The initial note, dated 2/04/12 at 3:45 PM, stated Patient #4 was placed in bilateral wrist restraints and a vest restraint. Between 2/04/12 at 3:45 PM and 2/07/12 at 8:00 AM, "Restraint Non-Violent Form" assessments were completed by nursing staff every 2 hours and contained documentation indicating "Behavior for restraining continues." The only exception to this occurred on 2/05/12 at 10:00 AM when the nurse documented "Sleeping and unable to evaluate cooperation." During this time that Patient #4 was restrained, the "Restraint Non-Violent Form" did not include specific documentation as to why she needed continued restraint. Patient #4's medical record contained a "Direct Charting Flowsheet" to document a variety of nursing assessment items such as vital signs, skin assessments, neurological assessments, IV assessments, behavior assessments, and other items. Documentation on the "Direct Charting Flowsheet" indicated Patient #4 was agitated on 2 occasions, on 2/05/12 at 4:00 PM and 8:00 PM. Otherwise, nursing documentation, between 2/04/12 at 3:45 PM and 2/07/12 at 8:00 AM, indicated Patient #4 was calm, cooperative, and occasionally confused or restless. No "Direct Charting Flowsheet" documented Patient #4 exhibited specific behavior that required restraint. The RAC, interviewed on 4/26/12 beginning at 12:50 PM, confirmed the documentation lacked the specific behaviors that indicated Patient #4 required continued restraint. The facility failed to ensure Patient #4's restraints	A 174		

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A 174	Continued From page 27 were discontinued at the earliest possible time. 5. Patient #6's medical record documented a 57 year old woman admitted to the hospital on 4/17/12 and remained a patient on the orthopedic/joint unit at the time of the survey. Patient #6 was admitted for care related to mild encephalopathy (brain dysfunction syndrome) attributed to low-grade sepsis (whole body inflammatory state) and/or electrolyte imbalance. The initial "Restraint Non-Violent Form," dated 4/19/12 at 11:00 PM, indicated soft restraints were applied to Patient #6's right arm. Between 4/19/12 at 12:00 AM and 4/22/12 at 12:00 AM, "Restraint Non-Violent Form" assessments were completed by nursing staff every 2 hours with the exception of an assessment on 4/20/12 at 4:00 AM, 4:00 PM, and 6:00 PM. The documentation indicated "Behavior for restraining continues," or "continue restraint." In addition, on 4/20/12 at 8:00 AM, 10:00 AM, 12:00 PM, and 2:00 PM the RN documented a sitter was present with Patient #6. On 4/21/12 at 2:00 AM, 4:00 AM, 6:00 AM, and 8:00 AM the nurse documented "Sleeping and unable to evaluate cooperation" when documenting the evaluation to discontinue restraints. The RN documented that each of Patient #6's wrists were restrained on 4/21/12 at 10:00 AM. During the time Patient #6 remained restrained, from 4/19/12 at 11:00 PM to 4/22/12 at 12:00 AM the "Restraint Non-Violent Form" did not include specific documentation as to why she needed continued restraint. The RAC, interviewed on 4/30/12 beginning at 9:30 AM, confirmed the documentation lacked the specific behaviors that indicated Patient #6	A 174		

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A 174	Continued From page 28 required continued restraint. The facility failed to ensure Patient #6's restraints were discontinued at the earliest possible time.	A 174		
A 185	482.13(e)(16)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:] A description of the patient's behavior and the intervention used. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure a description of the patient's behavior was documented for 5 of 6 sample patients (#1, #2, #3, #4, and #6) who were physically restrained. This resulted in the potential for patients to be restrained unnecessarily. The findings include: 1. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 with primary diagnoses of alcoholism with alcohol withdrawal. He was discharged on 2/20/12. A physician's "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment. The physician "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor. A physician's order, dated 2/06/12 at 5:19 AM, initiated soft restraints to both ankles and wrists to "To Ensure Patient Safety". The order stated the restraints could be released when Patient #2	A 185		

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A 185	Continued From page 29 was "...no longer Attempting to Harm Self." A "Restraint Non-Violent Form" was completed by an RN on 2/06/12 at 6:08 AM. It stated "Observed Behaviors for Restraint" were "Unable to follow instructions and attempts to discontinue equipment, Unable to follow instructions and pulling at tubes and lines, Unable to maintain balance/ambulate unassisted and refuses/is unable to ask for assistance." Subsequent "Restraint Non-Violent Forms" did not provide consistent documentation of behaviors that warranted the on-going use of restraints. A physician's order, dated 2/07/12 at 7:41 AM, called for soft restraints to wrists and ankles. The nursing "Restraint Non-Violent Forms" documented 2/07/12 at 6:00 AM and 8:00 AM stated "Behavior for restraining continues." There was no clear description of Patient #2's behavior that warranted the use of restraints. A physician order, dated 2/11/12 at 7:26 AM, called for hand mitts to both hands and soft restraints to wrists and ankles. Patient #2 was also ordered to have 1:1 supervision, a staff with him at all times. Though 1:1 supervision was ordered, the "Restraint Non-Violent Form," completed by an RN on 2/11/12 at 8:00 AM, stated Patient #2 remained in 4 point soft ankle and wrist restraints and had mitts applied to both hands. At the time a 1:1 staff was ordered, documentation could not be found that clearly identified Patient #2's behavior that necessitated the on-going use of the soft restraints to his wrists and ankles and hand mitts. Another physician's order, dated 2/13/12 at 4:03 PM, initiated a vest and soft restraints to both	A 185		

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A 185	Continued From page 30 ankles and wrists. The nursing "Restraint Non-Violent Forms," documented on 2/13/12 at 4:00 PM and 6:00 PM, stated "Behavior for restraining continues." A clear description of Patient #2's behavior that warranted the ongoing use of restraints could not be found. The RAC was interviewed on 4/26/12 beginning at 8:00 AM. She reviewed the record and confirmed consistent and specific documentation of Patient #2's behavior that warranted the use of restraints could not be found. The hospital failed to ensure a description of the behaviors that warranted the use of restraints was clearly and consistently documented for Patient #2. 2. Patient #4's medical record documented an 82 year old female admitted to the facility on 2/04/12 for care related to increased confusion and agitation and a related history dementia and psychosis. She was discharged on 2/08/12. A physician's order, dated 2/04/12 at 2:38 PM, called for the use of soft restraints to both wrists and ankles. According to "Restraint Non-Violent Form," Patient #4 remained in non-violent medical restraints until 2/07/12 at 8:00 AM, when restraints were discontinued. A consistent description of Patient #4's behavior that warranted the on-going use of restraints could not be found. A physician's order, dated 2/05/12 at 7:35 AM, called for the use of soft bilateral restraints to Patient #4's wrists and ankles. The order stated Patient #4 could be released from restraints when	A 185		

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she was no longer "Attempting to Harm Others." The nursing "Restraint Non-Violent Forms", dated 2/05/12 at 4:00 AM, 6:00 AM and 7:45 AM did not document specific behavior indicating a need for continued restraints. The form also failed to assess mood and affect. The only terms documented for "Cognitive/Emotional Response" were "Resisting Restraints or Not Resisting Restraints." The only phrase documented for "RN Eval for Discontinuing Restraints" was "Behavior for restraining continues." There was no consistent and clear description of Patient #2's behavior that warranted the on-going use of restraints.

The nursing "Direct Charting Flowsheet" in Patient #4's record documented her behavior, mood and affect as calm and/or cooperative on 2/04/12, 2/05/12 and 2/06/12. Documentation of behavior that warranted the continued use of restraints could not be found.

The RAC was interviewed on 4/26/12 beginning at 12:50 PM. She reviewed the record and confirmed consistent and specific documentation of Patient #4's behavior that warranted the use of restraints could not be found.

The hospital failed to ensure a description of the behaviors that warranted the use of restraints was clearly and consistently documented for Patient #4.

3. Patient #6's medical record documented a 57 year old woman who was admitted to the hospital on 4/17/12 and remained a patient on the orthopedic/joint unit at the time of the survey. Patient #6 was admitted for care related to mild

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A 185	Continued From page 32 encephalopathy (brain dysfunction syndrome) attributed to low-grade sepsis (whole body inflammatory state) and/or electrolyte imbalance. A physician ordered soft wrist restraints for Patient #6 on 4/19/12 at 2:48 AM. The nursing "Restraint Non-Violent Forms" contained a limited description of Patient #6's behavior that warranted the on-going use of restraints. For example, "Resisting Restraints or Not Resisting Restraints" and/or "Behavior for restraining continues" were documented on 4/20/12 from 12:00 AM through 4/21/12 at 8:00 PM. Descriptions of Patient #6's behavior for which the restraints were used could not be found during this time span. The RAC was interviewed on 4/30/12 beginning at 9:50 AM. She reviewed the record and confirmed it was the hospital's policy that an accurate description of the patient's behavior be documented and these could not be found. The hospital failed to ensure a description of the behaviors that warranted the use of restraints was clearly and consistently documented for Patient #6. 4. Patient #1's medical record documented a 47 year old female admitted to the facility on 1/30/12. According to the "History and Physical" dated 1/30/12 at 6:20 PM, Patient #1 was admitted through the ED for care related to alcohol detoxification secondary to substance abuse. The medical record contained conflicting information as to whether Patient #1 was discharged on 2/09/12 or 2/10/12.	A 185		

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A 185	Continued From page 33 On 2/06/12 at 12:13 AM, a physician order for "Restraint: Soft Limb X2" was written. The order stated the reason for the restraint was "To ensure patient safety." No specific behavior was described. A nursing "Restraint Non-Violent Form," dated 2/06/12 at 12:13 AM, documented Patient #1 was "Unable to maintain balance/ambulate unassisted and refuses/is unable to ask for assistance." The note stated wrist restraints were applied. Documentation of specific behavior that required restraining Patient #1 was not included in the note. "Restraint Non-Violent Forms" documented Patient #1 continued in restraints until 2/06/12 at 4:00 PM. A specific description of Patient #1's behavior was not documented at that time either. The "Restraint Non-Violent Form," dated 2/06/12 at 4:00 PM stated "MD wants trial of no restraints and pt [patient] can get out of wrist restraints." On 2/07/12 at 2:41 AM, a physician order for "Restraint: Vest" was written. The order stated the reason for the restraint was "To ensure patient safety." Again, no specific behavior was mentioned. Patient #1's first nursing "Restraint Non-Violent Form," on 2/07/12 was written at 4:00 AM. The note stated a vest restraint was applied at that time. The note stated Patient #1 was "Unable to follow instructions and attempts to discontinue equipment" and was "Unable to maintain balance/ambulate unassisted and refuses/is unable to ask for assistance." The note stated a vest restraint was applied. Documentation of specific behavior that required restraining Patient #1 was not documented. "Restraint Non-Violent	A 185		

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A 185	Continued From page 34 Forms" documented Patient #1 continued in restraints until 2/07/12 at 6:55 PM. A specific description of Patient #1's behavior was not documented at that time. The "Restraint Non-Violent Form," dated 2/06/12 at 6:55 PM stated "MD would like to attempt pt [patient] without restraints." The RAC, interviewed on 4/24/12 beginning at 12:30 PM, confirmed the documentation for Patient #1. She stated she could not find documentation of specific behavior that indicated Patient #1 required restraint. She stated the phrases "Unable to follow instructions and attempts to discontinue equipment" and "Unable to maintain balance/ambulate unassisted and refuses/is unable to ask for assistance" were part of the electronic medical record's programming. She stated nurses would click those items from a list of phrases on a screen and the text would be inserted into the medical record. Staff did not document a specific description of Patient #1's behavior that indicated a need for restraint. 5. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and who was currently a patient as of 4/30/12. Diagnoses included schizophrenia and dementia. On 3/18/12 at 1:35 AM, a physician order for "Restraint: Vest, Soft Limb X2" was written. The order stated the reason written for the restraint was "To ensure patient safety." No specific behavior was mentioned.	A 185		

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A 185	Continued From page 35 Nursing "Restraint Non-Violent Forms" documented Patient #3 was restrained on 3/18/12 at 2:00 AM. The note stated a vest and wrist restraints were applied. The note stated "Observed Behaviors for Restraints: Unable to follow instructions and attempts to discontinue equipment." A specific description of Patient #3's behavior was not documented. The type of equipment he was reportedly attempting to discontinue was not documented. "Restraint Non-Violent Forms" documented Patient #3 was kept in restraints until 10:00 AM on 3/18/12. On 3/30/12 at 5:26 PM, Patient #3's medical record documented a physician order for "Restraint: Soft Limb X4." The order stated the reason written for the restraint was "Protect from injury." No specific behavior was mentioned. A nursing "Restraint Non-Violent Form" documented Patient #3 was restrained on 3/30/12 at 6:00 PM. The note stated it was a "Restraint Assessment." The note did not state the type of restraints applied to Patient #3. The note stated Patient #3 was not resisting the restraints and stated "Discontinue restraint." However, the restraints were not discontinued and no further documentation was found to explain the phrase. The next "Restraint Non-Violent Form" was dated 3/30/12 at 8:00 PM. It did not state what type of restraint was used for Patient #3 but stated he was resisting the restraints. The note also stated "Behavior for restraining continues." The specific behavior that required placing Patient #3 in restraints was not documented. Nursing "Restraint Non-Violent Forms" documented Patient #3 remained in restraints until 4/06/12 at	A 185		

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A 185	Continued From page 36 8:00 AM. The RAC was interviewed on 4/26/12 beginning at 10:00 AM. She confirmed documentation of specific behavior was not documented. Staff did not document a description of Patient #3's behavior that indicated a need for restraint.	A 185		
A 187	482.13(e)(16)(iv) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:] The patient's condition or symptom(s) that warranted the use of the restraint or seclusion. This STANDARD is not met as evidenced by: Based on staff interview and review clinical records, it was determined the hospital failed to ensure the symptoms that warranted the use of the restraints was documented for 6 of 6 sample patients (#1, #2, #3, #4, #5, and #6) who were physically restrained. This lack of documentation had the potential to interfere with patients being restrained only when necessary to ensure their safety or the safety of others. Findings include: Patient #1's medical record documented a 47 year old female admitted to the facility on 1/30/12. According to the "History and Physical" dated 1/30/12 at 6:20 PM, Patient #1 was admitted through the ED for care related to alcohol detoxification secondary to substance abuse. The medical record contained conflicting information as to whether Patient #1 was discharged on 2/09/12 or 2/10/12.	A 187		

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	130007	A. BUILDING _____ B. WING _____	C 05/01/2012

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A 187	Continued From page 37 On 2/06/12 at 12:13 AM, a physician order for "Restraint: Soft Limb X2" was written. The order stated the reason for the restraint was "To ensure patient safety." An individualized assessment which identified the condition or symptoms that warranted the use of restraint was not documented by the physician. A nursing "Restraint Non-Violent Form," dated 2/06/12 at 12:13 AM, documented Patient #1 was "Unable to maintain balance/ambulate unassisted and refuses/is unable to ask for assistance." The note stated wrist restraints were applied. An individualized assessment which identified the specific symptoms that warranted the use of restraint was not documented by a nurse. "Restraint Non-Violent Forms" documented Patient #1 continued in restraints until 2/06/12 at 4:00 PM. On 2/07/12 at 2:41 AM, a physician order was written for "Restraint: Vest." The order stated the reason for the restraint was "To ensure patient safety." A physician progress note dated 2/07/12 at 8:54 AM, stated Patient #1 was agitated last night but it did not include an assessment which identified the condition or symptoms that warranted the use of restraint. The first nursing "Restraint Non-Violent Form," was documented in Patient #1's record on 2/07/12 at 4:00 AM. The note stated a vest restraint was applied at that time. The note stated Patient #1 was "Unable to follow instructions and attempts to discontinue equipment" and was "Unable to maintain balance/ambulate unassisted and refuses/is unable to ask for assistance." The specific	A 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 187	Continued From page 38 symptoms that warranted the use of restraint were not documented by the nurse. The RAC, interviewed on 4/24/12 beginning at 12:30 PM, confirmed the documentation for Patient #1. She stated she could not find documentation of symptoms that indicated Patient #1 required restraint. Staff did not document Patient #1's condition or symptoms that warranted the use of restraints. 2. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. Diagnoses included schizophrenia and dementia. On 3/18/12 at 1:35 AM, a physician order for "Restraint: Vest, Soft Limb X2" was written. The order stated the reason for the restraint was "To ensure patient safety." An assessment which identified the condition or symptoms that warranted the use of restraint was not documented by the physician. Nursing "Restraint Non-Violent Forms" documented Patient #3 was restrained on 3/18/12 at 2:00 AM. The note stated a vest and wrist restraints were applied. The note stated "Observed Behaviors for Restraints: Unable to follow instructions and attempts to discontinue equipment." An assessment which identified the specific conditions or symptoms that warranted the use of restraint was not documented. On 3/30/12 at 5:26 PM, a physician order for "Restraint: Soft Limb X4" was written. The order	A 187		

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A 187	Continued From page 39 stated the reason for the restraint was "Protect from injury." An assessment which identified the conditions or symptoms that warranted the use of restraint was not documented by the physician. A nursing "Restraint Non-Violent Forms" documented Patient #3 was restrained on 3/30/12 at 6:00 PM. The note stated it was a "Restraint Assessment." The note stated Patient #3 was not resisting the restraints and it stated "Discontinue restraint." However, the restraints were not discontinued and no further documentation regarding the intent of this phrase was found. The next nursing "Restraint Non-Violent Form" was dated 3/30/12 at 8:00 PM. It did not state what type of restraint was used for Patient #3 but stated he was resisting the restraints. The note also stated "Behavior for restraining continues." An assessment which identified Patient #3's specific conditions or symptoms that warranted the use of restraint was not documented. The RAC was interviewed on 4/26/12 beginning at 10:00 AM. She was not able to explain the note on 3/30/12 at 6:00 PM stating the restraint was discontinued. She did confirm assessments of Patient #3 showing the use of restraints was warranted, were not present in the record. Staff did not document Patient #3's condition or symptoms that warranted the use of restraints. 3. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 with primary diagnoses of alcoholism with alcohol withdrawal. He was discharged on 2/20/12. The physician's	A 187		

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A 187	Continued From page 40 "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment. The physician "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor. A physician's order, dated 2/06/12 at 5:19 AM, initiated soft restraints bilaterally to Patient #2's ankles and wrists to "To Ensure Patient Safety". The order stated the restraints could be released when Patient #2 was "no longer Attempting to Harm Self." An individualized assessment which included the conditions or symptoms Patient #2 exhibited, was not documented. The "Restraint Non-Violent Form" was completed by an RN on 2/06/12 at 6:08 AM. It stated the justification for the restraints were to "Maintain equipment/tube to support MED MGMT, Protect from injury." Further documentation included "Unable to follow instructions and attempts to discontinue equipment, Unable to follow instructions and pulling at tubes and lines, Unable to maintain balance/ambulate unassisted and refuses/is unable to ask for assistance." An assessment of Patient #2 which included the specific symptoms or conditions which warranted the use of the restraints was not found in Patient #2's record. A physician order, dated 2/11/12 at 7:26 AM, indicated Patient #2 was to have 1:1 supervision, a staff with him at all times. Though 1:1 supervision was ordered, the "Restraint Non-Violent Form", completed by an RN on 2/11/12 at 8:00 AM, stated Patient #2 remained in 4 point soft ankle and wrist restraints and had	A 187		

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A 187	Continued From page 41 mitts applied to both hands. At the time a 1:1 staff was ordered, documentation could not be found that identified Patient #2's condition and/or symptoms that necessitated the on-going use of the soft restraints to his wrists and ankles and hand mitts. The RAC was interviewed on 4/26/12 beginning at 8:00 AM. She confirmed it was the policy of the hospital that the use of restraints was based on an individualized assessment of the patient and should include a description of the patient's condition and/or symptoms that warranted the use of restraints. She confirmed the information was missing in Patient #2's record, but was unable to explain the discrepancy. The hospital failed to ensure the symptoms and/or conditions that warranted the use of restraints were documented in Patient #2's medical record. 4. Patient #4's medical record documented an 82 year old female admitted to the facility on 2/04/12 for care related to increased confusion and agitation and a related history dementia and psychosis. She was discharged on 2/08/12. A physician's order, dated 2/04/12 at 2:38 PM, called for the use of soft restraints to both wrists and ankles "To Ensure Patient Safety". The order indicated Patient #4 could be released from restraints when she was no longer attempting to harm others. An individualized assessment of Patient #4's conditions or symptoms that warranted the use of the restraints was not documented.	A 187		

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A 187	Continued From page 42 A physician's order, dated 2/05/12 at 7:35 AM, called for the use of soft bilateral restraints to Patient #4's wrists and ankles "To Ensure Patient Safety". The order stated Patient #4 could be released from restraints when she was no longer "Attempting to Harm Others." Evidence of a comprehensive restraint assessment that clearly outlined Patient #4's condition and/or symptoms that warranted the initiation of the restraints could not be found. The RAC was interviewed on 4/26/12 beginning at 12:50 PM. She confirmed it was the policy of the hospital that the use of restraints was based on an individualized assessment of the patient and should include a description of the patient's condition and/or symptoms that warranted the use of restraints. She confirmed the information was missing in Patient #4's record, but was unable to explain the discrepancy. Patient #4 was physically restrained without an assessment of his symptoms or conditions that warranted the use of restraint. 5. Patient #5's medical record documented he was a 74 year old male who was admitted to the facility on 4/06/12 for care related to sub-acute delirium or increased confusion, hallucinations and disordered thinking. He was discharged on 4/13/12. A physician's order, dated 4/08/12 at 4:41 PM, initiated the use of soft bilateral restraints to Patient #5's wrists and ankles. The order indicated the reason for the restraints was "Harmful to Self." Another order dated, 4/08/12 at 4:57 PM, and immediately following the order for	A 187		

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A 187	Continued From page 43 soft ankle and wrist restraints, documented the same information with the addition of "Restraint: Vest." An individualized assessment which included the conditions or symptoms which warranted the use of the wrist, ankle, and vest restraint, was not documented. The RAC was interviewed on 4/26/12 beginning at 12:50 PM. She confirmed the information was missing in Patient #5's record, but was unable to explain the discrepancy. Restraints were applied to Patient #5 without an assessment of his symptoms or conditions to verify the need for restraint. 6. Patient #6's medical record documented a 57 year old woman who was admitted to the hospital on 4/17/12 and remained a patient on the orthopedic/joint unit at the time of the survey. Patient #6 was admitted for care related to mild encephalopathy (brain dysfunction syndrome) attributed to low-grade sepsis (whole body inflammatory state) and/or electrolyte imbalance. A physician ordered soft bilateral wrist restraints for Patient #6 on 4/19/12 at 2:48 AM. The order indicated the justification for the restraints was to "Maintain Equip/Tube to Support Med Mgmt. Release when no longer Attempting to Harm Self." An individualized assessment of Patient #6's conditions or symptoms that warranted the restraint was not documented. The RAC was interviewed on 4/30/12 beginning at 9:30 AM. She confirmed it was the policy of the hospital that the use of restraints was based on an individualized assessment of the patient	A 187		

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A 187	Continued From page 44 and should include a description of the patient's condition and/or symptoms that warranted the use of restraints. She confirmed the information was missing in Patient #6's record, but was unable to explain the discrepancy. Patient #6's conditions and symptoms were not assessed prior to the use of restraint.	A 187		
A 188	482.13(e)(16)(v) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:] The patient's response to the intervention(s) used, including the rationale for continued use of the intervention. This STANDARD is not met as evidenced by: Based on review of clinical records and hospital policies and staff interviews, it was determined the hospital failed to ensure the medical records of 6 of 6 sample patients (#1, #2, #3, #4, #5 and #6) who were physically restrained, included documentation of the patient's response to the restraints and rationale for continued use. The lack of documentation impeded the ability of hospital staff to effectively assess the need for and effectiveness of the restraints. Findings include: 1. Patient #1's medical record documented a 47 year old female admitted to the facility on 1/30/12 for altered mental status and alcohol detoxification. The medical record contained conflicting information as to whether Patient #1 was discharged on 2/09/12 or 2/10/12.	A 188		

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A 188	Continued From page 45 A physician order for Patient #1 for restraints was dated 1/30/12 at 5:12 PM. The order was for 4 side rails up on her bed and bilateral wrist restraints. Nursing "Restraint Non-Violent Forms" documented Patient #1 continued in restraints until 2/05/12 at 2:00 PM. The "Restraint Non-Violent Forms" were documented every 2 hours while Patient #1 was restrained. Except for 4:00 AM and 6:00 AM on 2/04/12, all of Patient #1's "Restraint Non-Violent Forms" documented "Behavior for restraining continues." All of the "Restraint Non-Violent Forms" stated either "Resisting restraints" or "Not resisting restraint." No specific behaviors were described. Patient #1's response to the restraints, including a specific rationale for their continued use, was not documented. The RAC, interviewed on 4/24/12 beginning at 12:30 PM, confirmed the documentation for Patient #1. She confirmed Patient #1's response to the restraints was not clearly documented. Hospital staff did not document Patient #1's response to the restraints. 2. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. He was admitted for combative behavior. A physician order, dated 3/30/12 at 5:26 PM, called for "Restraint: Soft Limb X4 [wrists and	A 188		

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A 188	Continued From page 46 ankles]." "Restraint Non-Violent Forms" documented Patient #3 was restrained from 3/30/12 at 8:00 PM until 4/06/12 at 8:00 AM. The "Restraint Non-Violent Forms" were documented every 2 hours while Patient #3 was restrained. All of Patient #3's "Restraint Non-Violent Forms" documented "Behavior for restraining continues." All of the "Restraint Non-Violent Forms" stated either "Resisting restraints" or "Not resisting restraint." No specific behaviors were described. Patient #3's response to the restraints, including a specific rationale for their continued use, was not documented. The RAC, interviewed on 4/25/12 beginning at 11:10 AM, confirmed the documentation for Patient #3. She confirmed Patient #3's response to the restraints was not clearly documented. Hospital staff did not document Patient #3's response to the restraints and rationale for continued use. 3. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 with primary diagnoses of alcoholism with alcohol withdrawal. He was discharged on 2/20/12. A physician's order, dated 2/06/12 at 5:19 AM, initiated soft restraints to both ankles and wrists. The "Restraint Non-Violent Form" was completed by an RN on 2/06/12 at 6:08 AM. The form documented Patient #2's cognitive and emotional response as "Resisting restraints." Patient #2's response to the restraints was not clearly	A 188		

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A 188	Continued From page 47 documented. Nursing "Restraint Non-Violent Forms" documented Patient #2 remained in restraints until 2/16/12 at 4:00 PM. A physician's order, dated 2/07/12 at 7:41 AM, called for soft restraints to Patient #2's wrists and ankles. The order did not document Patient #2's response to restraints. The nursing "Restraint Non-Violent Forms" documented on 2/07/12 at 6:00 AM and 8:00 AM stated "Behavior for restraining continues." Patient #2's cognitive, emotional, and behavioral response to restraints was not documented at 6:00 AM. The documented response at 8:00 AM was "Resisting restraints." A clear description of Patient #2's behavior and his response to restraints was not documented. A physician's order, dated 2/13/12 at 4:03 PM, called for a restraint vest and soft restraints to Patient #2's ankles and wrists. The order did not document Patient #2's response to restraints. The nursing "Restraint Non-Violent Form," documented on 2/13/12 at 4:00 PM and 6:00 PM, stated "Behavior for restraining continues." Patient #2's response was documented as "Not resisting restraints." There was no clear description of Patient #2's behavior or his response to restraints. The RAC was interviewed on 4/26/12 beginning at 8:00 AM. She reviewed the record and confirmed Patient #2's response to restraints was not clearly documented. Hospital staff did not clearly document Patient #2's response to restraints.	A 188		

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A 188	Continued From page 48 4. Patient #4's medical record documented an 82 year old female admitted to the facility on 2/04/12 for care related to increased confusion and agitation and a related history of dementia and psychosis. She was discharged on 2/08/12. A physician's order, dated 2/04/12 at 2:38 PM, called for the use of soft restraints to both wrists and ankles. The "Restraint Non-Violent Form," dated 2/04/12 at 3:45 PM, did not document Patient #4's response to restraints. A physician's order, dated 2/05/12 at 7:35 AM, called for the use of soft bilateral restraints to Patient #4's wrists and ankles. The nursing "Restraint Non-Violent Form", dated 2/05/12 at 4:00 AM, 6:00 AM and 7:45 AM documented Patient #4's cognitive and emotional response to restraints as "Resisting Restraints or Not Resisting Restraints." Patient #4's specific behaviors were not clearly described on the form. There was no clear description of Patient #4's behavior or his response to restraints, including a specific rationale for continued use of restraints. The RAC was interviewed on 4/26/12 beginning at 12:50 PM. She reviewed the record and confirmed Patient #4's response to restraints was not clearly documented. Hospital staff did not document Patient #4's response to restraints. 5. Patient #5's medical record documented a 74 year old male who was admitted to the facility on 4/06/12 for care related to sub-acute delirium or increased confusion, hallucinations and disordered thinking. He was discharged on	A 188		

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A 188	Continued From page 49 4/13/12. A physician's order, dated 4/08/12 at 4:41 PM, called for the use of soft bilateral restraints to Patient #5's wrists and ankles. Another order dated, 4/08/12 at 4:57 PM, and immediately following the order for soft ankle and wrist restraints, documented the same information with the addition of a restraint vest. The nursing "Restraint Non-Violent Form," dated 4/08/12 at 6:00 PM, and 4/09/12 at 4:00 AM to 10:00 AM, documented Patient #5's cognitive and emotional response during this time was "Resisting Restraints" or "Sleeping." There was no clear description of Patient #5's behavior or his response to restraints, including a specific rationale for continued use of restraints. The RAC was interviewed on 4/25/12 beginning at 11:10 AM. She reviewed the record and confirmed Patient #5's response to restraints was not clearly documented. Hospital staff did not document Patient #5's response to restraints. 6. Patient #6's medical record documented a 57 year old woman who was admitted to the hospital on 4/17/12 and remained a patient on the orthopedic/joint unit at the time of the survey. Patient #6 was admitted for care related to mild encephalopathy (brain dysfunction syndrome) attributed to low-grade sepsis (whole body inflammatory state) and/or electrolyte imbalance. A physician ordered soft wrist restraints for Patient #6 on 4/19/12 at 2:48 AM. On 4/20/12 from midnight through 4/21/12 at 8:00 PM, the	A 188		

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A 188	Continued From page 50 nursing "Restraint Non-Violent Form" documented Patient #6's cognitive and emotional response as "Resisting restraints or "Not resisting restraints," with one exception on 4/20/12 at 8:00 PM when "Other: is resistant only at times to restraints" was documented. There was no clear description of Patient #6's behavior or his response to restraints. The RAC was interviewed on 4/25/12 beginning at 11:10 PM. She reviewed the record and confirmed Patient #6's response to restraints was not clearly documented. Hospital staff did not document Patient #6's response to restraints.	A 188		
A 431	482.24 MEDICAL RECORD SERVICES The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital. This CONDITION is not met as evidenced by: Based on staff interview and review of medical records, policies, and incident reports, it was determined the hospital failed to ensure the medical records service maintained responsibility for medical records at the hospital. In addition, it was determined the hospital failed to ensure a complete medical record was maintained for 6 of 6 patients (#1, #2, #3, #4, #5, and #6) whose medical records were reviewed. This resulted in a lack of evidence that the care provided to patients was responsive to their needs and compliant with physician orders. Findings include:	A 431		

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A 431	Continued From page 51 1. The Director of Health Information Management was interviewed on 5/01/12 beginning at 1:35 PM. She stated the Health Information Management Department was responsible for the coding, storage, back-up, and security of medical records. She stated the department was responsible for the accuracy and completeness of physician records as well as laboratory records, radiology records, and ancillary services. The Director of Health Information Management stated the Health Information Management Department had not assumed responsibility for the completeness of nursing documentation. She stated all nursing documentation was was the responsibility of the nursing department and the Clinical Informatics Department which managed the software nurses used to document. She stated the Health Information Management Department monitored and conducted quality reviews of physician documentation and ancillary services. However, She stated the Health Information Management Department did not monitor or include nursing documentation in their quality reviews. The DPSRC was interviewed on 5/01/12 at 3:55 PM. She stated the hospital had not implemented a policy defining who was responsible for oversight of the entire medical record including the completeness and accuracy of nursing documentation. The medical records department of the hospital did not assume responsibility for the entire medical record.	A 431		

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A 431	Continued From page 52 2. The hospital failed to ensure the medical record clearly described patients progress and response to services. Refer to A449 as it relates to the lack of documentation describing patients' response to services. 3. The hospital failed to ensure the medical record entries were complete. Refer to A450 as it relates to incomplete medical records. The cumulative effect of these systemic omissions resulted in the inability of the hospital to document the care patients received.	A 431		
A 449	482.24(c) CONTENT OF RECORD The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records, incident reports, and hospital policies, it was determined the hospital failed to ensure the medical record clearly described patients' progress and response to services for 6 or 6 patients (#1, #2, #3 #4, #5, and #6) whose records were reviewed. This resulted in a lack of clarity regarding the care and services planned and provided to patients and patients' progress and response to those services. Findings include: 1. Patient #1's medical record documented a 47 year old female who was admitted to the hospital on 1/30/12 for altered mental status and alcohol	A 449		

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A 449	Continued From page 53 detoxification. The medical record contained conflicting information as to whether Patient #1 was discharged on 2/09/12 or 2/10/12. The body of the "Discharge Summary," dictated at 10:21 PM on 2/10/12, stated Patient #1 was discharged on 2/10/12 while the identifying information on the discharge summary stated she was discharged on 2/09/12. a. A note in Patient #1's medical record, labeled "Case Management Assessment," was dated 2/01/12 at 4:03 PM. It stated: "Living Arrangements...House Level of Functioning...Ambulatory Physical Care Provider...Independent Financial Situation...No insurance coverage, No prescription coverage Community Resources...Arranged Initial Plan...Home." A "Direct Charting Flowsheet," dated 2/01/12 at 12:00 PM stated Patient #1 was only oriented to person and was only able to follow 1 step commands. The "Case Management Assessment" did not mention Patient #1's poor mental status or her need for supervision. The assessment did not state who she lived with or if supervision and assistance were available upon discharge. The assessment did not state what community resources were arranged. The assessment did not identify Patient #1's discharge planning needs. At the time of the assessment, Patient #1's was restrained. This also was not mentioned in the assessment.	A 449		

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A 449	Continued From page 54 The next and final documented Case Management progress note was dated 2/08/12 at 3:48 PM. It stated Patient #1 was not appropriate for treatment at an alcohol rehabilitation facility. Patient #1's medical record did not state where she was discharged to. The Case Manager was interviewed on 4/24/12 beginning at 11:07 AM. She stated Case Managers were responsible for discharge planning at the hospital. She stated case managers reviewed patients for discharge planning on a daily basis. She stated she did not know why there was no Case management documentation for 7 days for Patient #1. She also confirmed the medical record did not state where Patient #1 was discharged. b. Patient #1's medical record documented a nursing "Restraint Non-Violent Form," at 4:00 AM on 2/07/12. The note stated a vest restraint was applied to Patient #1 at that time. Even though it was timed at 4:00 AM, the note stated it was actually written at 5:39 AM. The physician order for the vest restraint was dated 2/07/12 at 2:42 AM. The time of the order did not correspond to the "Restraint Non-Violent Form." It was not clear if the restraint was actually applied at the time of the order or when it was documented. Neither the order nor the "Restraint Non-Violent Form" explained the time difference. The RAC was interviewed on 4/24/12 beginning at 12:30 PM. She confirmed the time Patient #1 was restrained was not clear. She stated sometimes nurses were busy and did not	A 449		

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A 449	Continued From page 55 document events until later in their shifts. c. Patient #1's nursing "Restraint Non-Violent Form," dated 1/30/12 at 6:00 PM, stated "Type of Restraint-All side rails up, Soft limb X2." Nursing "Restraint Non-Violent Forms" documented restraint usage every 2 hours between 1/30/12 at 6:00 PM and 2/05/12 at 2:00 PM when restraints were discontinued. After the initial note on 1/30/12 at 6:00 PM, the type of restraint used was not documented again by nursing staff, even though the type of restraints ordered changed over time as follows: A physician's order, dated 1/30/12 at 5:12 PM, stated "Restraint: Soft Limb X 2...rails X 4." A physician's order, dated 1/31/12 at 4:45 PM, stated "Restraint: Soft Limb X 4" A physician's order, dated 2/01/12 at 5:25 PM, stated "Restraint: Soft Limb X 2." A physician's order, dated 2/02/12 at 11:55 AM, stated "Restraint: Soft Limb X 4." A physician's order, dated 2/03/12 at 1:38 PM, stated "Restraint: Soft Limb X 4." A physician's order, dated 2/04/12 at 10:16 AM, stated "Restraint: Soft Limb X 2." A physician's order, dated 2/05/12 at 9:12 AM, stated "Restraint: Soft Limb X 2." A physician's order, dated 2/06/12 at 12:12 AM, stated "Restraint: Soft Limb X 2."	A 449		

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A 449	Continued From page 56 A physician's order, dated 2/07/12 at 2:41 AM, stated "Restraint: Vest." A physician progress note, dated 1/31/12 at 1:20 PM, stated Patient #1 was in "2 point soft restraints on upper extremity." No documentation was present explaining why 4 point restraints were ordered on 1/30/12 for Patient #1 or why side rails were not ordered to be continued, as they had been in the previous order on 1/30/12. A physician progress note, dated 2/04/12 at 12:26 PM, did not mention the type of restraints in use for Patient #1. No documentation was present explaining why 2 point restraints were ordered on 2/05/12 for Patient #1 when she had been in 4 point restraints on 2/03/12 and 2/04/12. An assessment of the changing restraint needs for Patient #1 was not documented. A nursing "Restraint Non-Violent Form," dated 2/06/12 at 12:13 AM, stated "Unable to maintain balance/ambulate unassisted and refuses/is unable to ask for assistance." The note stated Patient #1 was placed in bilateral wrist restraints. "Restraint Non-Violent Forms" documented Patient #1 remained in restraints until 4:00 PM on 2/06/12, when they were discontinued. The note did not state why the restraint was not applied until 4:00 AM, 1 hour and 19 minutes after the order was written. No nursing note indicating a problem requiring restraint was documented at the time the order was written. A nursing "Restraint Non-Violent Form," at 4:00 AM on 2/07/12, stated a vest restraint was applied. The nursing note stated Patient #1 was "Unable to follow instructions and attempts to discontinue equipment" and was "Unable to	A 449		

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maintain balance/ambulate unassisted and refuses/is unable to ask for assistance." The note did not state what type of equipment Patient #1 was trying to discontinue or how placing her in a vest would prevent that.

The nursing "Direct Charting Flowsheet," dated 2/06/12 at 4:00 PM, 8:00 PM, and 2/07/12 at 12:00 AM, stated Patient #1 was calm, oriented to person, and able to follow 1 step commands. The nursing "Direct Charting Flowsheet," dated 2/07/12 at 4:00 AM, stated Patient #1 was agitated and restless. The note did not describe specifically what this meant. There was no documentation describing patient behavior that would indicate the need for restraint.

The RAC, interviewed on 4/24/12 beginning at 12:30 PM, confirmed the documentation for Patient #1. She stated she could not tell what type of restraint was used for Patient #1 at what time. She confirmed the reasons for the use of restraint were not clearly documented. She stated items documented on the "Restraint Non-Violent Forms" and the "Direct Charting Flowsheets" were chosen from a list on a computer screen. The nurse would pick the item that approximated behavior associated with the patient and click on it. That item, such as "Unable to follow instructions and attempts to discontinue equipment" was then included in the medical record. The RAC stated it was difficult for staff to document items specific to the behavior of patients.

In addition, the RAC was interviewed on 4/24/12 beginning at 10:45 AM. She stated she reviewed medical records for restraint usage. She stated

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she did not review medical records to determine the reason for restraint usage because it was too difficult to find information in the medical records.

d. A social work note in Patient #1's medical record, dated 2/03/12 at 11:06 AM, stated "MSW [spoke with] pt sister [name], requested she bring in his shoes when she comes to visit next. Met with pt. He is friendly and happy as finishing his PT. Will follow." This note was obviously written for another patient as Patient #1 was a confused female who did not receive PT services. It was not misfiled because the author, who was Patient #1's social worker, had to log in to Patient #1's medical record in order to enter the information.

The Social Worker was interviewed on 4/24/12 beginning at 11:20 AM. She confirmed the documentation and stated she did not know who it referred to.

Information on Patient #1's medical record did not accurately describe he care, progress, and discharge information.

2. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. He had diagnoses of schizophrenia and dementia.

a. Patient #3's "Care Plans," initiated on 3/14/12, included "IPOC Adult Core-Deficient Knowledge...IPOC Adult Core-Difficulty Coping R/T Hospital Stay...IPOC Adult Core-Falls-Risk of...IPOC Comprehension of Social/Discharge Services-Deficient Knowledge Re: Health Resources [initiated 3/13/12]...IPOC Adult

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A 449	Continued From page 59 Core-Deficient Knowledge [initiated 3/18/12]..." No direction to staff as to how they should care for Patient #3 was documented as part of the POC. For example, the Deficient Knowledge POC did not specify what knowledge Patient #3 was deficient in or how staff should approach the problem. Instead, the POC listed "Adequate knowledge of Disease Process-Achieved or Progressing" and staff documented on an intermittent basis "Progressing, Unchanged, or Achieved." No explanation was documented. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. Given Patient #3's psychiatric and mental status, it could not be determined what the POC goal and subsequent documentation meant in relation to his care. For example, five consecutive notes by the RN were documented for the problem of "Deficiant Knowledge." These included: 4/08/12 at 1:34 PM-Progressing 4/08/12 at 11:35 AM-Achieved 4/08/12 at 11:20 PM-Progressing 4/09/12 at 7:50 AM-Achieved 4/13/12 at 6/28 PM-Unchanged The POC labeled "Difficulty Coping R/T Hospital Stay" also did not include direction to staff. The documentation stated "Effective Coping Behavior-Achieved or Progressing." RN staff documented. 4/08/12 at 1:34 PM-Progressing 4/08/12 at 11:35 AM-Achieved 4/08/12 at 11:20 PM-Progressing	A 449		

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A 449	Continued From page 60 4/09/12 at 7:50 AM-Achieved 4/13/12 at 6/28 PM-Unchanged 4/14/12 at 4:20 PM-Unchanged 4/16/12 at 5:24 AM-Unchanged Other items that were not addressed in Patient #3's POC included restraints which were described above, problems voiding which were documented from 3/30/12 through 4/08/12, his psychiatric diagnoses, a urinary tract infection which was diagnosed on 4/14/12, the use of sitters, and contact isolation which was initiated on 4/18/12. A nursing "Handoff Form," dated 3/16/12 at 7:58 AM, stated "Pt. had one episode of being verbally aggressive tonight. Pt. stated aggression was towards male sitter. Pt. is more calm with female sitters." Patient #3's POC did not mention the use of female sitters. The POC was reviewed with the RAC on 4/26/12 beginning at 10:30 AM. She confirmed specific direction to staff was not included in the POC. She stated for items such as restraints, interventions were not listed on a plan because they were listed in policy. She was not able to explain what progressing, unchanged, and achieved meant in relation to the documentation. She stated the EMR limited nurses' ability to document specific plans for patient care. The Manager of the Medical Floor was interviewed on 4/26/12 beginning at 10:45 AM. She reviewed the POC. She stated staff knew Patient #3 very well and had specific ways of interacting with him. She stated staff did not give him direct commands like "Sit down here."	A 449		

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A 449	Continued From page 61 Instead, they approached him softly asking him if he would like to sit down. She stated this had greatly improved his episodes of aggression. She confirmed that his POC did not include specific direction to staff as to how to approach Patient #3. She also stated staff used a gait belt to ambulate Patient #3. She confirmed the POC did not direct staff to use a gait belt when ambulating him. b. Restraint documentation in Patient #3's medical record was not clear. Patient #3's "ED Physician Notes" were dated 3/12/12 at 10:12 PM. The note stated Patient #3 had a history of schizophrenia and dementia. The note stated he had come from a nursing home after increased aggression and striking a nurse in the abdomen. The note stated Patient #3 was calm at first but "...became aggressive with the staff, was trying to leave, and actually required restraint and chemical sedation." "Emergency Room Progress Notes" by an RN, at 6:41 PM on 3/12/12, stated Patient #3 was walking in hallways and other patients' rooms. He became verbally aggressive and was placed in wrist restraints at 6:42 PM. The restraints were removed at 9:15 PM that evening. An order for the wrist restraints was not present in the medical record. The RAC was interviewed on 4/26/12 beginning at 10:00 AM. She confirmed the order for restraint was not documented. A physician's order at 1:36 AM on 3/26/12, called for "Restraint: Soft Limb X4." No nursing documentation was present stating restraints	A 449		

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A 449	Continued From page 62 were applied at this time. A nursing "Restraint/Seclusion-Violent Form," dated 3/26/12 at 7:55 AM, stated Patient #3 attempted to leave the floor and wandered into other patients' rooms. The form stated he was "swinging out at security." The form stated "Security held pt at four points while nursing staff applied soft restraints to legs and chest." The form stated "Type of Restraint...Soft limb X2. Vest...Restraints Applied to-Ankle, bilateral." A nursing note that explained why restraints were applied to Patient #3's ankles and not to his wrists, or how this would keep Patient #1 from swinging at staff, was not documented. A physician order for restraints corresponding to this nursing note was not documented. The next order for restraint following their application was written at 7:57 PM on 3/26/12. A nursing "Restraint Non-Violent Form," dated 3/26/12 at 8:04 AM, stated Patient #3's restraints were discontinued at 8:00 AM. The next "Restraint Non-Violent Form," dated 3/26/12 at 8:05 AM, stated "Post Surgical Restraint Applied" at 8:00 AM including "Soft limb X2, vest,Ankles Bilateral." The competing notes were not explained in the medical record. Also, Patient #1 did not have surgery so it was not clear what "Post Surgical Restraint" meant. The first physician "Progress Note" following the initiation of restraints was dated 3/26/12 at 4:58 PM. The note stated Patient #3 had become "...quite aggravated, agitated, screaming, spitting, etc. at about 9:00 this morning." The note did not document that restraints had been applied or whether they needed to be continued.	A 449		

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A 449	Continued From page 63 The RAC was interviewed on 4/25/12 beginning at 11:10 AM. She confirmed the restraint documentation for 3/26/12 and stated she could not explain the discrepancies. c. A nursing "Restraint Non-Violent Form," dated 3/18/12 at 1:37 AM, stated Patient #3 was "Unable to follow instructions and attempts to discontinue equipment." The form did not state what equipment Patient #3 was trying to discontinue. In fact, nursing notes did not doucment any equipment or tubes in use for Patient #3 on 3/18/12. The "Restraint Non-Violent Form" also did not explain what behavior the patient exhibited that caused him to be a danger to himself or others and required restraints to protect him. The "Restraint Non-Violent Form" stated restraints were applied including "All side rails up, soft limb X2 [wrist restraints], and vest." The next restraint form was dated 3/18/12 at 4:59 AM. It stated Patient #3 was not resisting the restraints but said "Behavior for restraining continues." This same language was documented on the "Restraint Non-Violent Form" at 6:13 AM and 10:17 AM. The restraint form at 11:21 AM on 3/18/12 stated Patient #3 was able to ambulate safely and there was an "Absence of behavior requiring restraint." The corresponding physician order, dated 3/18/12 at 1:35 AM, called for vest and wrist restraints to be applied. An order to raise all side rails, which constituted a separate restraint, was not documented. The RAC was interviewed on 4/25/12 beginning at 11:10 AM. She confirmed the documentation and was not able to explain the discrepancies.	A 449		

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A 449	Continued From page 64 d. A physician order for Patient #3, dated 3/25/12 at 4:54 PM, stated "Restraint: soft limb X4...Release when no longer Attempting to Harm Self." An order for a vest restraint was not documented. A physician order, dated 3/25/12 at 4:56 PM, stated "Restraint: Therapeutic Hold. Release when no longer Attempting to Harm Self. Hands on restraint to assist patient back to room." A corresponding nursing "Restraint Non-Violent Form," dated 3/25/12 at 4:05 PM, stated Patient #3 was "...kicking and elbowing at staff." The form did not describe the events leading up to Patient #3's outburst. The form stated "Type of Restraint...Soft limb X2. Vest, Other: Security physically hands on to escort pt to room, and keep in his bed until restraints can be applied. Restraints Applied to-Ankle, bilateral, Chest." The form indicated ankle restraints had been applied but did not state he was placed in wrist restraints as called for in the order. The form stated the restraints were discontinued at 4:45 PM on 3/25/12. A nursing "Restraint Non-Violent Form" for Patient #3, dated 3/25/12 at 4:45 PM, stated restraints were applied including "Type of Restraint...Soft limb X2. Vest Restraint Applied to-Ankle, bilateral, Chest." A nursing "Restraint Non-Violent Form" for Patient #3, dated 3/25/12 at 6:10 PM, stated restraints were discontinued at that time. The medical record for Patient #3 was not clear as to when the patient was restrained and why 2 point restraints were applied when 4 point	A 449		

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A 449	Continued From page 65 restraints were ordered and why a vest restraint was applied without an order. The RAC was interviewed on 4/25/12 beginning at 11:10 AM. She confirmed Patient #3's documentation and was not able to explain the discrepancies. e. A nursing "Restraint Non-Violent Form," dated 3/26/12 at 7:55 AM, stated Patient #3 attempted to leave the floor and wandered into other patients' rooms. The form stated security was called and Patient #3 became aggressive, swinging at them. The form stated "Security held pt at four points while nursing staff applied soft restraints to legs and chest." The form stated "Type of Restraint...Soft limb X2. Vest...Restraints Applied to-Ankle, bilateral." No physician order was present in the record for the restraints that were applied on 3/26/12 at 7:55 AM. Patient #3's nursing "Restraint Non-Violent Form," dated 3/26/12 at 8:04 AM, stated restraints were discontinued at 8:00 AM. The next "Restraint Non-Violent Form," dated 3/26/12 at 8:05 AM, stated restraints were initiated at 8:00 AM. The discrepancy was not explained in the medical record. The RAC was interviewed on 4/25/12 beginning at 11:10 AM. She confirmed the documentation and was not able to explain the discrepancy. f. Patient #3's "Restraint Non-Violent Forms" were documented every 2 hours between 3/26/12 at 8:00 AM and 4/06/12 at 8:00 AM with the	A 449		

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following exception: On 3/29/12, a form was not completed between 4:00 PM and 10:00 PM. No documentation was present to indicate Patient #3 was restrained during that time.

The RAC was interviewed on 4/25/12 beginning at 11:10 AM. She confirmed the documentation and was not able to explain the lack of documentation.

g. Patient #3's "Restraint Non-Violent Forms" stated they were a restraint assessment. However, they did not document specific behavior which indicated a continuing need for restraints. For example, Patient #3's "Restraint Non-Violent Forms" were documented every 2 hours between 3/26/12 at 8:00 AM and 4/06/12 at 8:00 AM. The forms did not describe Patient #3's emotional or behavioral status. Unless the restraint was being initiated or discontinued, the only items documented for "Cognitive/Emotional response" were "Resisting restraints" and "Not Resisting restraints." The only items documented for "RN Eval for Discontinuing restraints" were "Behavior for restraining continues" and "Sleeping and unable to evaluate cooperation."

The RAC was interviewed on 4/25/12 beginning at 11:10 AM. She confirmed there was not descriptive language in the medical record which explained the need for restraint.

h. A physician's order for Patient #3, dated 3/30/12 at 5:26 PM, called for "Restraint: Soft Limb X4." The order stated "Alternatives Tried: 1:1 intervention." A corresponding progress note by the physician, indicating an assessment of the need for restraint, was not present in the medical

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A 449	Continued From page 67 record. A nursing "Restraint Non-Violent Form," dated 3/30/12 at 6:00 PM, indicated Patient #3 was not restrained at that time. A nursing "Restraint Non-Violent Form," dated 3/30/12 at 8:00 PM, stated Patient #3 was "Resisting restraints" although it did not indicate what type of restraints were in use. The note stated "Alternatives to Restraints Attempted: Bed Alarm." Aside from the bed alarm, the note did not indicate what less restrictive measures had been attempted prior to utilizing restraints and did not describe how they were not successful. The RAC, interviewed on 4/25/12 beginning at 11:10 AM, confirmed the documentation for Patient #3. She stated the use of less restrictive measures and their results were not documented. i. The type of restraint utilized for Patient #3 was not documented. A physician order for Patient #3, dated 3/26/12 at 1:36 AM, stated "Restraint: Soft Limb X4." The corresponding nursing "Restraint Non-Violent Form" on 3/26/12 at 8:00 AM documented "Type of Restraint...Soft limb X2. Vest...Restraints Applied to-Ankle, bilateral." A physician order for Patient #3, dated 3/27/12 at 4:20 PM and 3/28/12 at 11:12 AM, stated "Restraint: Vest." The corresponding nursing "Restraint Non-Violent Form" on 3/27/12 at 4:00 PM documented Type of Restraint...Geri Chair...Restraints Applied to-Chest." The nursing note did not state why a Geri Chair was used as a restraint without an order.	A 449		

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A 449	Continued From page 68 Orders from 3/29/12 at 10:12 AM through 4/01/12 at 5:06 PM stated "Restraint: Soft Limb X4." The nursing "Restraint Non-Violent Forms" from 3/29/12 at 12:00 AM through 4/01/12 at 10:00 PM did not document what type of restraints were used for Patient #3. The order, dated 4/02/12 at 12:26 PM, stated "Restraint: Vest." None of the "Restraint Non-Violent Forms," completed every 2 hours from 4/02/12 at 2:00 AM through 10:00 PM, documented what type of restraints were used for Patient #3. The RAC was interviewed on 4/25/12 beginning at 11:10 AM. She confirmed the type of restraints used was not documented. j. Patient #3's medical record did not include documentation of significant events that affected his care. A "Post Fall Assessment Form," dated 3/26/12, stated Patient #3 had an un-observed fall on that date at 7:50 AM. The form stated there were no apparent injuries or complaints related to the fall. A "Post Fall Assessment Form," dated 3/29/12 at 9:20 PM, stated Patient #3 also had an observed fall on that date. Again, the form stated there were no apparent injuries or complaints related to the fall. The falls were not documented in Patient #3's medical record. The Medical Unit Manager reviewed Patient #3's medical record on 4/27/12 beginning at 2:45 PM. She stated the "Post Fall Assessment Form" was an internal event reporting form and was not part	A 449		

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A 449	Continued From page 69 of the medical record. She confirmed nursing documentation describing the falls and action taken by staff was not present in the record. "Post Fall Assessment Forms" were internal incident reports and were not part of the medical record. 3. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 with primary diagnoses of alcoholism with alcohol withdrawal. He was discharged on 2/20/12. A physician's "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment. A physician's "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor. Patient #2's medical record did not clearly document his goals, progress and response to the care and services provided as follows: a. A "Case Management Progress Note" was dated 2/14/12 at 2:47 PM. It stated Patient #2 lived with his wife in [a town 270 miles from Boise]. On 2/15/12 at 10:51 AM, a "Case Management Progress Note" stated "Anticipate pt will [discharge] to inlaws home in [a town 106 miles from Boise]. I scheduled new pt appt at [clinic name] in [a town 270 miles from Boise]." Patient #2 was discharged on 2/20/12. No other "Case Management Progress Note" or other documentation stated Patient #2's discharge destination. The medical record did not document clear discharge planning interventions or discharge	A 449		

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A 449	Continued From page 70 plans. A Case Manager was interviewed on 4/26/12 beginning at 8:00 AM. She stated case managers reviewed patients for discharge planning. She reviewed the medical record and was unable to state where Patient #2 was discharged to. b. A nursing "Restraint Non-Violent Form," dated 2/04/12 at 4:00 AM, documented bilateral wrist and ankle restraints were applied to Patient #2. A "History and Physical," dated 2/06/12 at 8:06 AM, documented Patient #2 was admitted to ICU on 2/06/12 at 4:15 AM. The note did not document he was agitated or required restraints. Patient #2's record included a physician's order, dated 2/06/12 at 5:19 AM, for soft restraints to both of his ankles and wrists. The physician did not document an assessment of need for restraints. Another physician's order, dated 2/07/12 at 6:42 PM, called for the use of a restraint vest, in addition to, the wrist and ankle restraints. Nursing "Restraint Non-Violent Forms," dated 2/07/12, did not document the restraint vest was applied. Hand mitts were also ordered on 2/08/12 at 10:07 AM. The "Restraint Non-Violent Forms," dated 2/08/12 did not document the application of mitts. The RAC was interviewed on 4/26/12 beginning at 8:00 AM. She reviewed the record and confirmed Patient #2's restraints was not clearly documented.	A 449		

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A 449	Continued From page 71 Hospital staff did not clearly document Patient #2's discharge planning and restraint information. 4. Patient #4's medical record documented an 82 year old female admitted to the facility on 2/04/12, for care related to increased confusion and agitation and a related history of dementia and psychosis. She was discharged on 2/08/12. A physician's order, dated 2/04/12 at 2:38 PM, called for the use of soft restraints to both wrists and ankles. The "Restraint Non-Violent Form," dated 2/04/12 at 3:45 PM, documented bilateral wrist restraints and a vest restraint were applied. The medical record did not state why the restraints applied did not match the order. The "History and Physical," dated 2/04/12 at 5:30 PM, documented Patient #4 was agitated, paranoid and hallucinating. It did not mention the need for restraints. An assessment of the need for restraints was not documented. The RAC was interviewed on 4/26/12 beginning at 12:50 PM. She reviewed the record and confirmed the medical record did not clearly document the use of restraints. Hospital staff did not document evaluations and care provided in relation to restraints. 5. Patient #5's medical record documented a 74 year old male who was admitted to the facility on 4/06/12 for care related to sub-acute delirium or increased confusion, hallucinations and disordered thinking. He was discharged on 4/13/12. A physician's order, dated 4/08/12 at 7:35 PM,	A 449		

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documented "Discontinue after: Therapeutic Hold Complete for IM Injection." The "Restraint Non-Violent Form," dated 4/08/12 at 4:35 PM, documented "Other: pt received Therapeutic hold and IM medication administered." The medical record did not document the reason the physical hold occurred prior to the time the order was entered. There was no physician's progress note on 4/08/12 that documented the event.

A physician's order for "Restraint/Seclusion Violent," dated 4/08/12 at 4:41 PM, called for the use of soft restraints to Patient #5's wrists and ankles. Immediately following was a physician's order "Restraint Order Non-Violent," dated 4/08/12 at 4:57 PM, called for use of a restraint vest. No documentation was present explaining why one order was for violent behavior and the other was for non-violent behavior. No assessment of the need for restraint was documented by the physician on 4/08/12.

The timing of the nursing documentation was unclear. The nursing "Restraint Non-Violent Form," dated 4/08/12 at 4:30 PM, documented "Therapeutic Hold." This nursing note was not written until 8:00 PM. The nursing "Restraint Non-Violent Form," dated 4/08/12 at 4:35 PM, was written at 8:04 PM and stated Patient #5 received a therapeutic hold and IM medication. The next "Restraint Non-Violent Form" was dated 4/08/12 at 4:35 PM. It stated restraints were discontinued. It was written at 11:42 PM. The next "Restraint Non-Violent Form" was dated 4/08/12 at 6:00 PM. It stated bilateral wrist and ankle and vest restraints were applied at 4:30 PM. It was written at 5:41 PM. The final "Restraint Non-Violent Form" was dated 4/08/12

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A 449	Continued From page 73 at 8:00 PM. It was written on 4/09/12 at 2:02 AM. It stated Patient #5 was resisting restraints and the behavior for restraining continued. The medical record did not clearly document when Patient #5 was restrained. The RAC was interviewed on 4/26/12 beginning at 12:50 PM. She reviewed the record and confirmed the medical record did not clearly document the use of restraints. Patient #5's medical record did not clearly document the use of restraints. 6. Patient #6's medical record documented a 57 year old woman who was admitted to the hospital on 4/17/12 and remained a patient on the orthopedic/joint unit at the time of the survey. Patient #6 was admitted for care related to mild encephalopathy (brain dysfunction syndrome) attributed to low-grade sepsis (whole body inflammatory state) and/or electrolyte imbalance. A physician ordered soft bilateral wrist restraints for Patient #6 on 4/19/12 at 2:48 AM. No documentation was present that a restraint was applied at that time. The first documented use of restraint was a nursing "Restraint Non-Violent Form," dated 4/19/12 at 11:00 PM. The note documented the use of 1 soft restraint to the right arm. The next restraint order was on 4/20/12 at 4:40 AM. The order called for bilateral wrist restraints. "Restraint Non-Violent Forms," dated 4/20/12, documented Patient #6 remained in restraints for the entire day. The type of restraints used was not documented. The RAC was interviewed on 4/26/12 beginning	A 449		

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A 449	Continued From page 74 at 12:50 PM. She reviewed the record and confirmed the medical record did not clearly document the use of restraints. Hospital staff did not clearly document the use of restraints.	A 449		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on staff interviews and review of medical records, policies, and incident reports, it was determined medical record entries were incomplete for 6 of 6 patients (#1, #2, #3, #4, #5, and #6) whose medical records were reviewed. This resulted in a lack of clarity related to patient care and the inability of the hospital to determine whether care had been provided. Findings include: 1. Patient #1's medical record documented a 47 year old female who was admitted to the hospital on 1/30/12 for altered mental status and alcohol detoxification. Patient #1's medical record was not complete. Examples include: a. The date and time of discharge were not documented. The identifying information on Patient #1's History and Physical, Discharge Summary, and physician Progress Notes all stated she was discharged on	A 450		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 450	Continued From page 75 2/09/12. The body of the "Discharge Summary," dictated at 10:21 PM on 2/10/12, stated Patient #1 "...was discharged on 2/10/12 to her parents' home, and with plan for outpatient detox." The medical record stopped on 2/09/12. The last physician order, dated 2/09/12 at 2:52 PM, stated to discharge Patient #1. It did not say where to. The last documented medication given was dated 2/09/12 at 2:30 PM. The last nursing note was a "Direct Charting Flowsheet, dated 2/09/12 at 3:32 PM. It stated Patient #1"s IV was discontinued. No progress note by nursing, social services, or the Case Manager was present in the record stating the date and time Patient #1 was discharged or where she was discharged to. Patient #1's Discharge Summary contained other inaccuracies. The summary stated "I appreciate the involvement of [name of social worker], who helped coordinate meeting with her family." This was in relation to facilitation of discharge planning. The social worker noted in the discharge summary above, was interviewed on 4/24/12 beginning at 11:43 PM. She stated she did not know Patient #1 and had not been involved in her care. The RAC was present during the interview with the social worker. She stated documentation of Patient #1's discharge date and time or where she was discharged to was not present in the medical record. b. The medical record did not document Patient #1's movement through the hospital. Patient #1's medical record documented she presented to the ED on 1/30/12 at 9:49 AM. The	A 450		

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A 450	Continued From page 76	A 450		

time Patient #1 was transferred to an inpatient unit from the ED was not documented. A "Emergency Room Progress Note" documented she was in the ED at 1:59 PM on 1/30/12. The nursing "Direct Charting Flowsheet," dated 1/30/12 at 3:35 PM, stated an "Adult Admission Assessment" had been ordered. Patient #1 was probably on the unit at this time. The time of arrival on the inpatient unit was not documented.

The RAC, interviewed on 4/24/12 beginning at 12:30 PM, was not able to state when Patient #1 was transferred to the inpatient unit.

c. Restraint documentation was not clear.

An "Emergency Room Progress Note," written by an RN at 12:44 PM on 1/30/12, stated Patient #1 was "...placed in posey due to multiple attempts to get out of bed and pulling on lines." The type of restraint(s) used were not specified. No other nursing notes related to restraints were documented in the ED. After the initial note, restraints were not documented until mentioned on a nursing "Restraint Non-Violent Form," dated 1/30/12 at 6:00 PM . The form stated Patient #1 had bilateral wrist restraints applied and all side rails up. The form stated it was a "Restraint Initiation Assessment" but the medical record did not state the restraints had been removed after being applied at 12:44 PM.

The first physician order for restraints was dated 1/30/12 at 5:12 PM. The order was for 4 side rails and bilateral wrist restraints. The order's time frame did not correspond to the time of the "Emergency Room Progress Note" or the "Restraint Non-Violent Form" dated 1/30/12 at

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A 450	Continued From page 77 6:00 PM. The RAC, interviewed on 4/24/12 beginning at 12:30 PM, was not able to explain the time discrepancy between Patient #1's order and the "Restraint Non-Violent Form." d. The medical record did not include the type of restraints used for Patient #1. Nursing "Restraint Non-Violent Forms" documented restraint usage every 2 hours between 1/30/12 at 6:00 PM and 2/05/12 at 2:00 PM, when they were discontinued. After the initial note on 1/30/12 at 6:00 PM, the type of restraint used was not documented again. A physician's order, dated 1/30/12 at 5:12 PM, stated "Restraint: Soft Limb X 2...rails X 4." A physician's order, dated 1/31/12 at 4:45 PM, stated "Restraint: Soft Limb X 4" A physician's order, dated 2/01/12 at 5:25 PM, stated "Restraint: Soft Limb X 2." A physician's order, dated 2/02/12 at 11:55 AM, stated "Restraint: Soft Limb X 4." A physician's order, dated 2/03/12 at 1:38 PM, stated "Restraint: Soft Limb X 4." A physician's order, dated 2/04/12 at 10:16 AM, stated "Restraint: Soft Limb X 2." A physician's order, dated 2/05/12 at 9:12 AM, stated "Restraint: Soft Limb X 2."	A 450		

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A 450	Continued From page 78 A physician's order, dated 2/06/12 at 12:12 AM, stated "Restraint: Soft Limb X 2." A physician's order, dated 2/07/12 at 2:41 AM, stated "Restraint: Vest." Because of the lack of documentation by nursing staff regarding the type of restraint utilized for Patient #1, it was not possible to determine whether restraint orders were followed or not. A physician progress note, dated 1/31/12 at 1:20 PM, stated Patient #1 was in "2 point soft restraints on upper extremity." No documentation was present explaining why 4 point restraints were ordered on 1/30/12 for Patient #1 or why side rails were not ordered to be continued, as they had been in the previous order on 1/30/12. A physician progress note, dated 2/04/12 at 12:26 PM, did not mention the type of restraints in use for Patient #1. No documentation was present explaining why 2 point restraints were ordered on 2/05/12 for Patient #1 when she had been in 4 point restraints on 2/03/12 and 2/04/12. An assessment of the changing restraint needs for Patient #1 was not documented. The RAC, interviewed on 4/24/12 beginning at 12:30 PM, stated she was not able to tell what restraints were in use at what time for Patient #1. She stated the documentation did not explain the rationale for the decisions to change restraint orders. e. Patient #1's POC was not complete. It did not direct staff in the care of patient #1. Patient #1's "Care Plans" form stated it was	A 450		

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A 450	Continued From page 79 initiated on 1/30/12 and completed on 2/09/12. The form listed "ED Stroke Panel, Alcohol Withdrawal-IV infusions, Alcohol Withdrawal, Alcohol Withdrawal-Heparin Subcut Medical Medical VTE Prophylaxis, Alcohol Withdrawal-Nausea and Vomiting, Restraint Orders." No documentation explaining what these terms meant or providing direction to staff was present on the "Care Plans" form. Patient #1's "Care Plans" form continued stating "IPOC Adult Core-Deficient Knowledge, IPOC Adult Core-Difficulty coping R/T Hospital Stay, IPOC Adult Core-Falls-Risk of, IPOC Risk of Injury to Self/Others & Suicide Prevention, IPOC Comprehension of Social/Discharge Services-Deficient Knowledge Re: Health Resources" None of the items listed under "Care Plans" contained direction to staff. Patient #1's "Care Plans" form did not make sense. For example, under "IPOC Risk of Injury to Self/Others & Suicide Prevention," was listed "Type of restraint-All side rails up or Elbow immobilizers or Enclosure bed/net bed or Geri chair, or Hard X2 or Hard X3 or Hard X4 or Lap Belt, or Merry walker, or Mitt X2 or Roll belt, or Side rail wedge or Soft limb X1 or Soft limb X2." No explanation of this list meant was included. No direction to staff was included in the documentation. The only restraints listed that were used for Patient #1 were side rails and soft limb X2. Soft limb X4 restraints were ordered on 1/31/12, 2/02/12, and 2/03/12 but were not listed on the form. A vest restraint was used on 2/07/12 but was also not listed. The RAC, interviewed on 4/24/12 beginning at	A 450		

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A 450	Continued From page 80 12:30 PM, confirmed Patient #1's care plans were confusing and did not provide direction to staff. 2. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. He was admitted for combative behavior. a. Two incident reports labeled "Current Summary" documented Patient #3 fell twice, once on 3/26/12 at 7:50 AM, and once on 3/28/12 at 9:20 PM. The falls were not documented in Patient #3's medical record. The Manager of the Medical Unit was interviewed on 4/27/12 beginning at 2:45 PM. She reviewed the medical record. She stated documentation of the falls was not present in the record. b. Restraint documentation was not complete. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. The note stated he came from a nursing home after increased aggression and striking a nurse in the abdomen. The note stated Patient #3 was calm at first but "...became aggressive with the staff, was trying to leave, and actually required restraint and chemical sedation." On 3/12/12, "Emergency Room Progress Notes" by an RN at 6:42 PM, stated Patient #3 was walking in hallways and other patients' rooms. The note stated he became verbally aggressive and was placed in wrist restraints at that time. The restraints were	A 450		

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A 450	Continued From page 81 removed at 9:06 that evening. An order for the wrist restraints was not present in the medical record. The RAC was interviewed on 4/26/12 beginning at 10:00 AM. She confirmed the order for restraint was not documented. In another incident, a nursing "Restraint Non-Violent Form" for Patient #3, dated 3/25/12 at 4:05 PM, stated restraints were applied including "Type of Restraint...Soft limb X2. Vest... Restraints Applied to-Ankle, bilateral, Chest." A corresponding physician order for a vest restraint was not found in Patient #3's record. A nursing "Restraint Non-Violent Form" for Patient #3, dated 3/25/12 at 4:45 PM, stated restraints were discontinued at that time. Another "Restraint Non-Violent Form" for Patient #3, dated 3/25/12 at 4:45 PM, stated "Post Surgical Restraints" were applied at the same time. Patient #3 appeared to remain restrained until 8:51 PM on 3/25/12. No documentation was present to explain the conflicting nursing notes. The RAC was interviewed on 4/25/12 beginning at 11:10 AM. She confirmed Patient #3's documentation and was not able to explain the discrepancies on 3/25/12. b. Patient #3's POC was not complete. It did not direct staff in the care of Patient #3. Patient #3's "Care Plans" form stated it was initiated on 3/12/12 and the plan was ongoing as of 4/25/12. The form listed "IPOC Comprehension of Social/Discharge Services-Deficient Knowledge Re: Health	A 450		

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A 450	Continued From page 82 Resources, IPOC Risk of Injury to Self/Others: With/without Restraints-Risk for Inj: Restraint Non-Violent Beh, IPOC Adult Core-Falls-Risk of, IPOC Adult Core-Difficulty coping R/T Hospital Stay. None of the items listed under "Care Plans" contained direction to staff. The "Care Plans" form was not clear and not complete. For example, under "IPOC Comprehension of Social/Discharge Services-Deficient Knowledge Re: Health Resources," the plan stated "Education Given-Amputee or Asthma or Bone graft/joint or Cancer or Cardiac or Chemical dependency issue, or CHF program or Community resources or Diabetes or Discharge planning/Other or Renal or Skilled Nursing Facili [sic]" Patient #3 was not an amputee. He did not have asthma or "Bone graft/joint or Cancer" or the other diagnoses listed in this section. A reason for educating Patient #3 on these issues was not documented. In addition, Patient #3 was disoriented and education was of limited value. Patient #3's POC stated "IPOC Risk of Injury to Self/Others: With/without Restraints-Risk for Inj: Restraint Non-Violent Beh [sic]." No direction to staff was documented. An outcome category, "Absence of Inadvertent Self-Injury-Achieved or Progressing," was listed next. Nursing "Restraint Non-Violent Forms" documented Patient #1 was restrained from 3/30/12 at 8:00 PM through 4/06/12 at 8:00 AM. Beneath the outcome heading, "Progressing" was charted on 3/30/12, 4/01/12, 4/03/12, and 4/05/12. Achieved was charted on 4/06/12. "Unchanged" was charted on 3/27/12 when Patient #3 was also restrained.	A 450		

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A 450	Continued From page 83 The meaning of these terms was not clear. No criteria was listed explaining what these terms meant. "IPOC Risk of Injury to Self/Others & Suicide Prevention," was listed "Type of restraint-All side rails up or Elbow immobilizers or Enclosure bed/net bed or Geri chair, or Hard X2 or Hard X3 or Hard X4 or Lap Belt, or Merry walker, or Mitt X2 or Roll belt, or Side rail wedge or Soft limb X1 or Soft limb X2." No explanation of what this list meant was included. No direction to staff was included in the documentation. No documentation in the record indicated any of these restraints were used for Patient #1 except side rails and soft limb X2. The restraints that were used on Patient #1 were not listed in the plan. The RAC, interviewed on 4/24/12 beginning at 12:30 PM, confirmed Patient #1's care plans were confusing and did not provide direction to staff. Dementia and schizophrenia were not listed as problems on Patient #3's plan of care. The Manager of the Medical Unit was interviewed on 4/26/12 beginning at 10:45 AM. She stated staff had specific ways of approaching Patient #3 in order to decrease the likelihood that he would become agitated. For example, she stated staff needed to not give him direct commands such as stand up or sit down. Rather, she stated staff needed to coax him into doing things and give him choices, such as asking him if he would like to sit down. She confirmed instructions to staff regarding how to approach Patient #3 were not included in his plan of care.	A 450		

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A 450	Continued From page 84 Patient #3's documentation was not complete. 3. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 and was discharged on 2/20/12. According to his "History and Physical," dated 2/06/12 at 8:06 AM, Patient #2's primary diagnosis was alcoholism with alcohol withdrawal. a. During Patient #2's hospitalization and according to the "Discharge Summary," dated 2/20/12 at 4:23 PM, he was reported to have "...required significant doses of benzodiazepines to control his tremulousness and DTs. This resulted in sedation and he had to be intubated to protect his airways." The "Discharge Summary" also stated Patient #2 "...went through significant delirium tremens and was resuscitated." He was reportedly confused and disoriented much of his hospitalization. The "Discharge Summary" also stated "...mental status improved, but he still had problems with some calculation and orientation to day, date and some timing of life events." A physician's progress note, dated 2/17/12 at 2:21 PM, stated "This morning he was noted to be confused and possibly hallucinating." The note later stated "If the patient's mental status does not clear, will consult neuropsychiatry for more thorough evaluation for possible cognitive defects. I do not feel comfortable discharging him home as he still remains disoriented." A "Case Management" note, dated 2/06/12 at 2:33 PM, stated Patient #2 was single and his home city was [town 9 miles from Boise]. A	A 450		

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A 450	Continued From page 85 "Case Management," note dated 2/14/12 at 2:47 PM, stated Patient #2 lived with his wife in [town 270 miles from Boise]. A "Social Work" note, entered on 2/14/12 at 3:03 PM, stated Patient #2 lived in [town 9 miles from Boise]. A "Case Management" note dated 2/15/12 at 10:51 AM stated "Anticipated pt will dc to inlaws home in [town 106 miles from Boise] area. I scheduled new pt appt at the [clinic name] in [town 270 miles from Boise]...." A physician's "Progress Note" dated 2/18/12 at 11:53 AM stated " ...He has no primary care physician established in [town 270 miles from Boise]. I do not feel the patient is yet safe to send home." The medical record did not positively identify Patient #2's place of residence. The Assistant Director of Case Management was interviewed on 4/26/12 at 9:15 AM. She reviewed Patient #2's record and was unable to confirm where Patient #2 went after discharge; to his in-law's home or with his wife. The Assistant Director was unable to identify Patient #2's primary place of residence. She could not identify a discharge plan. Patient #2's primary residence at the time of discharge was not documented. b. A physician's order, dated 2/06/12 at 5:19 AM, initiated non-violent, medical restraints for Patient #2, and stated "Soft Limb X 4." A nursing "Restraint Non-Violent Form," dated 2/16/12 at 4:00 PM, documented restraints were	A 450		

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A 450	Continued From page 86 discontinued. No orders to continue soft 4 point restraints were documented for the dates of 2/11/12 or 2/15/12. According to the "Restraint Non-Violent Forms," dated 2/11/12 and 2/15/12, Patient #2 remained in soft 4 point restraints. The RAC was interviewed on 4/26/12 at 8:00 AM. She reviewed the record and confirmed the documentation in Patient #2's medical record did not explain the order discrepancies. 4. Patient #4's medical record documented an 82 year old female admitted to the facility on 2/04/12 for care related to increased confusion and agitation and a related history of dementia and psychosis. She was discharged on 2/08/12. A physician's order, dated 2/04/12 at 2:38 PM, called for the use of soft restraints to both wrists and ankles "To Ensure Patient Safety." The order indicated Patient #4 could be released when she was no longer attempting to harm others. A nursing "Restraint Non-Violent Form," was completed by the RN on 2/04/12 at 3:45 PM. The RN indicated Patient #4 was in soft limb restraints X2 and a "Vest (modified)" restraint. Patient #5's medical record did not contain a physician's order for the use of a vest restraint on 2/04/12 at 3:45 PM. The RAC reviewed Patient #4's medical record on 4/26/12 at 8:00 AM. She confirmed that a physician's order for the vest restraint was not documented. 5. Patient #5's medical record documented a 74 year old male admitted to the facility on 4/06/12 for care related to subacute delirium, or increased	A 450		

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A 450	Continued From page 87 confusion, hallucinations and disordered thinking. He was discharged on 4/13/12. A physician's order, dated 4/10/12 at 8:12 AM, initiated soft restraints to bilateral wrists and ankles. The order indicated the reason for the restraints was "Harmful to Self." A nursing "Restraint Non-Violent Form" was completed by the RN on 4/10/12 at 8:00 AM. The RN indicated Patient #5's wrists and ankles were restrained and he was placed in a "Vest" restraint. The medical record did not contain a physician's order for the vest restraint. The RAC reviewed Patient #5's record on 4/26/12 at 8:00 AM. She confirmed that an order for the vest restraint documented on 4/10/12 at 8:00 AM was not found in the record. 6. Patient #6's medical record documented a 57 year old woman admitted to the hospital on 4/17/12 and remained a patient on the orthopedic/joint unit at the time of the survey. Patient #6 was admitted for care related to mild encephalopathy (brain dysfunction syndrome) attributed to low-grade sepsis (whole body inflammatory state) and/or electrolyte imbalance. A physician's order, dated 4/19/12 at 2:48 PM, stated "Restraint: Soft limb X 2." No documentation was present in the medical record that this order was carried out. The initial nursing "Restraint Non-Violent Form," completed by the RN on 4/19/12 at 11:00 PM, stated 1 soft limb restraint was placed on Patient #6's right arm. The medical record did not contain a physician's order for this restraint.	A 450		

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A 450	Continued From page 88 The RAC was interviewed on 4/30/12 at 9:30 AM. She reviewed Patient #6's medical record and confirmed the order for initiation of restraint on 4/19/12 at 11:00 PM was not present.	A 450		
A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure an effective discharge planning process had been developed and implemented. This prevented staff from consistently assessing discharge planning needs and developing discharge plans. Findings include: 1. Refer to A806 as it relates to the failure of the hospital to conduct discharge planning evaluations. 2. Refer to A808 as it relates to the failure of the hospital to conduct discharge planning evaluations that included an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. 3. Refer to A809 as it relates to the failure of the hospital to conduct discharge planning evaluations including an evaluation of the patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.	A 799		

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A 799	Continued From page 89 4. Refer to A817 as it relates to the failure of the hospital to develop discharge plans. 5. Refer to A821 as it relates to the failure of the hospital to reassess discharge planning options as patient needs changed. The cumulative effect of these negative facility practices impeded the hospital's ability to provide discharge planning services to patients.	A 799		
A 806	482.43(b)(1) DISCHARGE PLANNING NEEDS ASSESSMENT The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. This STANDARD is not met as evidenced by: Based on staff interview, record review, and review of hospital policies, it was determined the hospital failed to provide discharge planning evaluations for 3 of 6 patients (#1, #2, and #3) whose records were reviewed for discharge planning needs. The lack of an appropriate discharge evaluation had the potential to affect all patients and prevent patients' post-hospitalization needs from being met. Findings include: 1. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 and was discharged on 2/20/12. According to the "History and Physical," dated 2/06/12 at 8:06 AM, Patient #2's primary diagnosis was alcoholism with alcohol	A 806		

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A 806	Continued From page 90	A 806		

withdrawal. A physician's "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment of symptoms related to alcohol withdrawal. A physician "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor for continued treatment. According to the "Discharge Summary," dated 2/20/12, Patient #2 remained on the medical floor until discharge on 2/20/12 at 3:53 PM.

The "Discharge Summary," dated 2/20/12 at 4:23 PM, documented Patient #2 was reported to have "...required significant doses of benzodiazepines to control his tremulousness and DTs. This resulted in sedation and he had to be intubated to protect his airways." The "Discharge Summary" also stated Patient #2 "...went through significant delirium tremens and was resuscitated."

Patient #2 was reportedly confused and disoriented much of his hospitalization. A physician's progress note in Patient #2's record, dated 2/13/12 at 10:27 AM, documented "neuro: oriented x 1, but doesn't know the date. Does know he is in Boise after he says he is in [a town 303 miles from Boise]." Another physician's progress note, dated 2/17/12 at 2:21 PM, stated "This morning he was noted to be confused and possibly hallucinating." The note later stated "If the patient's mental status does not clear, will consult neuropsychiatry for more thorough evaluation for possible cognitive defects. I do not feel comfortable discharging him home as he still remains disoriented."

A "Case Management" note, dated 2/06/12 at

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A 806	Continued From page 91 2:33 PM, stated Patient #2 was single and he lived in [town 9 miles from Boise]. On 2/07/12 at 11:56 AM, the "Case Management" note stated "Pt is apparently married." The name of his wife was listed, along with her phone number. A "Case Management" note, dated 2/13/12 at 2:49 PM, stated Patient #2 required assisstance with mobility and ADLs'. The next "Case Management" note that mentioned his living situation was dated 2/14/12 at 2:47 PM. The note stated Patient #2 lived in [town 270 miles from Boise]. A "Social Work" note, entered on 2/14/12 at 3:03 PM, again stated Patient #2 lived in [town 9 miles from Boise]. A "Case Management" note, dated 2/15/12 at 10:51 AM, stated "Anticipated pt will dc to inlaws home in [town 106 miles from Boise]. I scheduled new pt appt at the [clinic name] in [town 270 miles from Boise]...." A physician's "Progress Note" dated 2/18/12 at 11:53 AM stated "The patient's social situation is tenuous as his wife is young and working fulltime and they have a 1-year old son at home, not a lot of social support. He has no primary care physician established in [town 270 miles from Boise]. I do not feel the patient is yet safe to send home." There was no documented discharge planning evaluation that described the amount and type of supervision Patient #2 would require after discharge and who would be available to provide supervision. Where Patient #2 went after discharge was not documented in his record. The Assistant Director of Case Management was	A 806		

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A 806	Continued From page 92 interviewed on 4/26/12 at 9:15 AM. She reviewed Patient #2's record and was unable to confirm where Patient #2 went after discharge; to his in-law's home or with his wife. She was unable to identify a discharge planning evaluation in the medical record. The facility failed to provide a thorough discharge planning evaluation that clearly assessed Patient #2's condition at time of discharge and how his condition would impact his post-hospitalization needs. 2. Patient #1's medical record documented a 47 year old female who was admitted to the hospital on 1/30/12. The "History and Physical," dated 1/30/12 at 6:20 PM, stated Patient #1 came from a residential alcohol treatment center where she "...became increasingly agitated with an altered level of consciousness." The note stated she was obtunded (mentally dulled). The identifying information on Patient #1's "Discharge Summary," dated 2/10/12 at 10:21 PM, stated she was discharged on 2/09/12. The body of the "Discharge Summary" stated Patient #1 was discharged on 2/10/12 to her parents' home. However, the medical record stopped on 2/09/12. The last physician order, dated 2/09/12 at 2:52 PM, stated to discharge Patient #1. It did not say where to. The last documented medication given was dated 2/09/12 at 2:30 PM. The last nursing note was a "Direct Charting Flowsheet, dated 2/09/12 at 3:32 PM. It stated Patient #1's IV was discontinued. No progress note by nursing, by social services, or by the Case Manager was present in the record stating the date and time Patient #1 was discharged or	A 806		

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A 806	Continued From page 93 where she was discharged to. A physician progress note, dated 1/31/12 at 1:20 PM, stated Patient #1 was in 2 point restraints and was "oriented X 0 [zero]." The note stated if Patient #1's mentation did not improve the physician would consider other causes than alcohol withdrawal. Physician and nursing progress notes documented Patient #1 stayed confused throughout her stay. She also remained in restraints from 1/30/12 to 2/07/12. A note in Patient #1's medical record was labeled "Case Management Assessment" and was dated 2/01/12 at 4:03 PM. It stated: "Living Arrangements...House Level of Functioning...Ambulatory Physical Care Provider...Independent Financial Situation...No insurance coverage, No prescription coverage Community Resources...Arranged Initial Plan...Home." The "Case Management Assessment" did not mention Patient #1's poor mental status or her need for supervision. The assessment did not state who she lived with or if supervision and assistance were available upon discharge. The assessment did not state what community resources were arranged. The assessment did not identify Patient #1's discharge planning needs. At the time of the assessment, Patient #1 was restrained. This also was not addressed in the assessment.	A 806		

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A 806	Continued From page 94 The next and final documented Case Management progress note was dated 2/08/12 at 3:48 PM. It stated Patient #1 had been receiving intermittent doses of antipsychotic medication and antianxiety medication. It stated Patient #1 was not appropriate for treatment at an alcohol rehabilitation facility. It stated the physician had requested a meeting with Patient #1's parents to discuss discharge. A complete discharge planning evaluation was not documented in Case Management notes. Social work notes were documented on 1/31/12, 2/01/12, 2/02/12, 2/03/12, 2/06/12, and 2/07/12. The first social work note identified Patient #1 had no insurance. Subsequent notes discussed the possibility of Patient #1 going to an inpatient alcohol rehabilitation facility. The final social work note, on 2/07/12 at 11:35 AM, stated Patient #1 was still in restraints and was disoriented. A complete discharge planning evaluation was not documented in social work notes. The Case Manger for Patient #1 was interviewed on 4/24/12 beginning at 11:07 AM. She was not able to find a complete discharge planning evaluation documented in the medical record. A discharge planning evaluation was not conducted for Patient #1. 3. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. He was	A 806		

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A 806	Continued From page 95 admitted for combative behavior. A "Case Management Assessment," dated 3/13/12 at 9:00 AM, stated Patient #3 lived in a long term care facility and was "Assisted by staff at extended care facility." It stated he had Medicare and Medicaid. It stated Patient #3 was placed on a mental hold. It also stated the long term care facility he came from refused to take him back. There were 33 Case Management notes documented in the medical record. However, a complete discharge planning evaluation, including identification of discharge planning needs, was not documented. The Case Manager and Social Worker were interviewed together on 4/25/12 beginning at 1:55 PM. They stated Patient #3 was still an inpatient because of discharge planning problems. They were not able to identify a complete discharge planning evaluation in the medical record. A complete discharge planning evaluation was not conducted for Patient #3. 4. The hospital policy, "DISCHARGE PLANNING," revised 11/10, stated the screening process for discharge planning needs was initiated on all patients by the RN using the "admission assessment tool." The policy stated referrals were made to the Case Manager for discharge planning based on the nursing assessment. The policy stated, "The [Case Manager] will complete a further review utilizing the assessment of the admitting nurse as well as his or her own evaluation of patient/family needs as they coordinate a plan for patients who are identified as having a need for more complex	A 806		

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A 806	Continued From page 96 discharge planning." The policy listed "Clinical Indicators which may identify a potential need for transition/discharge planning..." The policy did not identify a consistent approach to evaluating patients' discharge planning needs or how this would be documented. The Assistant Director for Case Management was interviewed on 4/26/12 beginning at 8:55 AM. She stated a discharge planning evaluation tool, or other process to provide consistency, had not been developed. She stated staff had to "glean" discharge planning needs from reading case management notes. The hospital had not developed a consistent discharge planning evaluation process to ensure patients' post-discharge needs were met.	A 806		
A 808	482.43(b)(3) POST-HOSPITAL SERVICES The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records and hospital policies, it was determined the hospital failed to evaluate the likelihood of patients needing post-hospital services and/or the availability of those services. This affected 3 of 6 patients (#1, #2, and #3) whose records were reviewed for discharge planning and had the potential to affect all inpatients. The lack of a system to evaluate the likelihood of patients needing post-hospital services had the potential to result in unmet patient needs after discharge. Findings include:	A 808		

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A 808	Continued From page 97 1. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 and was discharged on 2/20/12. According to the "History and Physical," dated 2/06/12 at 8:06 AM, Patient #2's primary diagnosis was alcoholism with alcohol withdrawal. A physician's "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment of symptoms related to alcohol withdrawal. A physician's "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor for continued treatment. According to the "Discharge Summary," dated 2/20/12, Patient #2 remained on the medical floor until discharged from the facility on 2/20/12 at 3:53 PM. According to Patient #2's "Discharge Summary," dated 2/20/12 at 4:23 PM, he was reported to have "...required significant doses of benzodiazepines to control his tremulousness and DTs. He was reportedly confused and disoriented much of his hospitalization. Patient #2's mental status was documented in a physician's progress note, dated 2/17/12 at 2:21 PM. The note stated, "This morning he was noted to be confused and possibly hallucinating." The note later stated "If the patient's mental status does not clear, will consult neuropsychiatry for more thorough evaluation for possible cognitive defects. I do not feel comfortable discharging him home as he still remains disoriented." A physician's "Progress Note," dated 2/18/12 at	A 808		

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A 808	Continued From page 98 11:53 AM, stated "The patient's social situation is tenuous as his wife is young and working fulltime and they have a 1-year old son at home, not a lot of social support. He has no primary care physician established in [town 270 miles from hospital]. I do not feel the patient is yet safe to send home." A discharge planning evaluation was not present in Patient #2's record. A "Case Management" note, dated 2/13/12 at 2:49 PM, stated, "requires assist with mobility and ADLs." A "Case Management" note, dated 2/15/12 at 10:51 AM, stated "Anticipated pt will dc to inlaws home in [town 106 miles from Boise]. I scheduled new pt appt at the [Clinic name] in [town 270 miles from Boise]...." No other "Case Management" notes documented an assessment of Patient #2's needs. Seven "Social Work" notes were documented between 2/07/12 and 2/20/12. None of the notes documented an assessment of Patient #2's post-discharge needs and services available to meet those needs. The Assistant Director of Case Management was interviewed on 4/26/12 at 9:15 AM. She reviewed Patient #2's record and was unable to confirm where Patient #2 went after discharge; to his in-law's home in [town 270 miles from Boise] or with Patient #2's wife in [town 9 miles from Boise]. She confirmed there was no discharge planning evaluation. 2. Patient #1's medical record documented a 47 year old female who was admitted to the hospital	A 808		

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A 808	Continued From page 99 on 1/30/12. The "History and Physical," dated 1/30/12 at 6:20 PM, stated Patient #1 came from a residential alcohol treatment center where she "...became increasingly agitated with an altered level of consciousness." The note stated she was obtunded (mentally dulled). Patient #1 was discharged on either 2/09/12 or 2/10/12. The "Discharge Summary," dated 2/10/12 at 10:21 PM, contained conflicting information about the dates. No progress note by nursing services, by social services, or by the Case Manager was present in the record stating the date and time Patient #1 was discharged or where she was discharged to. A "Case Management Assessment," dated 2/01/12 at 4:03 PM, stated Patient #1 lived in a house, was ambulatory, and was independent. The assessment stated Patient #1 had no insurance coverage and no prescription coverage. It stated substance abuse treatment was arranged and said Patient #1's initial plan was "home." The "Case Management Assessment" did not mention Patient #1's poor mental status or the need for supervision. The assessment did not include the likelihood of Patient #1 needing post-hospital services. The Case Manager for Patient #1 was interviewed on 4/24/12 beginning at 11:07 AM. She stated the plan for Patient #1 was always to discharge her back to the residential alcohol treatment center rather than home. She reviewed Patient #1's record and was not able to find a discharge planning evaluation that included the likelihood of Patient #1 needing post-hospital services. The Case Manager stated a specific	A 808		

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A 808	Continued From page 100 discharge planning evaluation which included items that should be assessed for all patients needing a discharge planning evaluation had not been developed. A discharge planning evaluation, including the likelihood of the need for post-hospital services, was not conducted for Patient #1. 3. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. He was admitted for combative behavior. A "Case Management Assessment," dated 3/13/12 at 9:00 AM, stated Patient #3 lived in a long term care facility and was "Assisted by staff at extended care facility." It stated he had Medicare and Medicaid. It stated Patient #3 was placed on a mental hold. It also stated the long term care facility he came from refused to take him back. The assessment did not include the likelihood of Patient #3 needing post-hospital services. Case Management notes and Social Work notes discussed the possibily of Patient #3 being discharged to a SNF, to an Assisted Livng Facility, to a niece's home, and to a 2 person Certified Family Home. Case Management notes and Social Work notes did not include an assessment of the need for specific post-hospital services Patient #3 required in order to develop a workable discharge plan.	A 808		

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	130007	A. BUILDING _____ B. WING _____	C 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTER	1055 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 808	Continued From page 101 The Case Manager and Social Worker were interviewed together on 4/25/12 beginning at 1:55 PM. They stated Patient #3 was still an inpatient because of discharge planning problems. They were not able to identify a complete discharge planning evaluation in the medical record including the likelihood of Patient #3 needing post-hospital services. A discharge planning evaluation, including the likelihood of the need for post-hospital services, was not conducted for Patient #3. 4. The hospital policy, "DISCHARGE PLANNING", revised 11/10, stated "The [Case Manager] will complete a further review utilizing the assessment of the admitting nurse as well as his or her own evaluation of patient/family needs as they coordinate a plan for patients who are identified as having a need for more complex discharge planning." The policy did not direct staff to evaluate patients for the likelihood of needing post-hospital services. The Assistant Director for Case Management was interviewed on 4/26/12 beginning at 8:55 AM. She confirmed the policy did not direct staff to evaluate patients for the likelihood of needing post-hospital services. The hospital had not developed a discharge planning evaluation process that included an evaluation of the likelihood of patients needing post-hospital services.	A 808		
A 809	482.43(b)(4) SELF CARE PATIENT EVALUATION The discharge planning evaluation must include	A 809		

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A 809	Continued From page 102 an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records and hospital policies, it was determined the hospital failed to evaluate patients' capacity for self-care and the possibility of patients being cared for in their home environment after discharge. This affected 3 of 6 patients (#1, #2, and #3) whose records were reviewed for discharge planning, and had the potential to affect all patients. This had the potential to result in unmet patient needs after discharge. Findings include: 1. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 and was discharged on 2/20/12. According to the "History and Physical," dated 2/06/12 at 8:06 AM, Patient #2's primary diagnosis was alcoholism with alcohol withdrawal. A physician's "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment of symptoms related to alcohol withdrawal. A physician "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor for continued treatment. According to the "Discharge Summary," dated 2/20/12, Patient #2 remained on the medical floor until discharged from the facility on 2/20/12 at 3:53 PM. According to Patient #2's "Discharge Summary,"	A 809		

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A 809	Continued From page 103 dated 2/20/12 at 4:23 PM, he was reported to have "...required significant doses of benzodiazepines to control his tremulousness and DTs. This resulted in sedation and he had to be intubated to protect his airways." The "Discharge Summary" also stated Patient #2 "...went through significant delirium tremens and was resuscitated." A physician's progress note, dated 2/13/12 at 10:27 AM, documented "neuro: oriented x 1, but doesn't know the date. Does know he is in Boise after he says he is in [town 303 miles from Boise]." Another physician's progress note, dated 2/17/12 at 2:21 PM, documented Patient #2's mental status. The note stated "This morning he was noted to be confused and possibly hallucinating." The note later stated "If the patient's mental status does not clear, will consult neuropsychiatry for more thorough evaluation for possible cognitive defects. The patient may have had an anoxic episode during his presentation. ...I do not feel comfortable discharging him home as he still remains disoriented." A physician's "Progress Note," dated 2/18/12 at 11:53 AM, stated, "The patient's social situation is tenuous as his wife is young and working fulltime and they have a 1-year old son at home, not a lot of social support.... I do not feel the patient is yet safe to send home." A "Case Management" note, dated 2/15/12 at 10:51 AM, stated "Anticipated pt will dc to inlaws home in [town 106 miles from Boise] area. I scheduled new pt appt at the [clinic name] in [town 270 miles from Boise]...."	A 809		

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A 809	Continued From page 104 A "Social Work" note, dated 2/20/12 at 4:27 PM, stated "...he will be referred to Brain Injury Rehab program. He has been instructed that he is not to drive, return to work, operate power tools and abstain from all alcohol. Discharge to home. [Physician's name] will interview pt's wife for additional history." The Assistant Director of Case Management was interviewed on 4/26/12 at 9:15 AM. She reviewed Patient #2's record and was unable to confirm where Patient #2 went after discharge; to his in-law's home in [town 270 miles from the hospital] or with his wife in [town 9 miles from Boise]. Supporting documentation could not be found that explained whether the facility verified Patient #2's ability to care for himself in the home. Additionally, there was no mention of the availability of family to supervise Patient #2 in the home if need be. The facility failed to evaluate Patient #2's capacity for self-care and ability to function in the home environment with or without supervision. 2. Patient #1's medical record documented a 47 year old female who was admitted to the hospital on 1/30/12. The "History and Physical," dated 1/30/12 at 6:20 PM, stated Patient #1 came from a residential alcohol treatment center where she "...became increasingly agitated with an altered level of consciousness." The note stated she was obtunded (mentally dulled). Patient #1 was discharged on either 2/09/12 or 2/10/12. No progress note by nursing, by social services, or by the Case Manager was present in the record stating the date and time Patient #1	A 809		

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A 809	Continued From page 105 was discharged or where she was discharged to. Patient #1 was confused and presented with discharge planning needs. A physician's progress note, dated 1/31/12 at 1:20 PM, stated Patient #1 was in 2 point restraints and was "oriented X 0 [zero]." A "Case Management Assessment," dated 2/01/12 at 4:03 PM, stated Patient #1 lived in a house, was ambulatory, and was independent. The assessment stated Patient #1 had no insurance coverage and no prescription coverage. It stated substance abuse treatment was arranged and said Patient #1's initial plan was "home." The "Case Management Assessment" did not mention Patient #1's impaired mental status or the need for supervision. The assessment did not include an assessment of the likelihood of Patient #1's capacity for self-care. The Case Manager for Patient #1 was interviewed on 4/24/12 beginning at 11:07 AM. She confirmed a discharge planning evaluation that included the likelihood of Patient #1's capacity for self-care could not be found in Patient #1's record. A discharge planning evaluation, including the likelihood of Patient #1's capacity for self-care, was not conducted. 3. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. The "ED Physician Notes," dated 3/12/12 at 10:12 PM, stated Patient #3 had a	A 809		

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A 809	Continued From page 106 history of schizophrenia and dementia. He was admitted for combative behavior. A "Case Management Assessment," dated 3/13/12 at 9:00 AM, stated Patient #3 lived in a long term care facility prior to admission and was "Assisted by staff at extended care facility." It stated Patient #3 was placed on a mental hold. It also stated the long term care facility he came from refused to take him back. The assessment did not include the likelihood of Patient #3's capacity for self-care. It did not evaluate Patient #3's ability to perform his own activities of daily living. It did not evaluate how much supervision he might need such as whether he needed to be discharged to a locked facility or not. Subsequent Case Management notes as well as Social Service notes did not evaluate these items. The Case Manager and Social Worker were interviewed together on 4/25/12 beginning at 1:55 PM. They stated Patient #3 was still an inpatient because of discharge planning problems. They were not able to identify a discharge planning evaluation in the medical record which included the likelihood of Patient #3's capacity for self-care. A discharge planning evaluation for Patient #3, including his ability to care for himself, was not conducted. 4. The hospital policy, "DISCHARGE PLANNING", revised 11/10, stated, "The [Case Manager] will complete a further review utilizing the assessment of the admitting nurse and as	A 809		

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A 809	Continued From page 107 well as his or her own evaluation of patient/family needs as they coordinate a plan for patients who are identified as having a need for more complex discharge planning." The policy did not direct staff to evaluate patients for self care ability and the likelihood of returning to the environment they came from. The Assistant Director for Case Management was interviewed on 4/26/12 beginning at 8:55 AM. She confirmed the policy did not direct staff to evaluate patients for the likelihood of patients' capacity for self-care or the possibility they could return to the environment from where they came. The hospital had not developed a discharge planning evaluation process that included an evaluation of patients self care abilities and the likelihood of returning to the environment they came from.	A 809		
A 817	482.43(c) DISCHARGE PLAN Discharge Plan This STANDARD is not met as evidenced by: Based on staff interview and medical record and hospital policy review, it was determined the hospital failed to develop discharge plans for 3 of 6 patients (#1, #2, and #3) whose records were reviewed for discharge planning. This resulted in the potential for patients to experience adverse events after discharge. Findings include: 1. Patient #2's medical record documented a 29 year old male who was admitted to the facility through the ED on 2/06/12 and was discharged on 2/20/12. According to the "History and Physical," dated 2/06/12 at 8:06 AM, Patient #2's	A 817		

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A 817	Continued From page 108 primary diagnosis was alcoholism with alcohol withdrawal. A physician's "Critical Care Progress" note, dated 2/06/12 at 1:58 PM, documented Patient #2 was transferred from the ED to ICU for continued treatment of symptoms related to alcohol withdrawal. A physician's "Critical Care Progress" note, dated 2/11/12 at 7:11 AM, indicated Patient #2 was transferred to the medical floor for continued treatment. According to the "Discharge Summary," dated 2/20/12, Patient #2 remained on the medical floor until discharged from the facility on 2/20/12 at 3:53 PM. According to Patient #2's "Discharge Summary," dated 2/20/12 at 4:23 PM, he was reported to have "...required significant doses of benzodiazepines to control his tremulousness and DTs. This resulted in sedation and he had to be intubated to protect his airways." The "Discharge Summary" also stated Patient #2 "...went through significant delirium tremens and was resuscitated." A physician's progress note, dated 2/13/12 at 10:27 AM, documented "neuro: oriented x 1, but doesn't know the date. Does know he is in Boise after he says he is in [town 303 miles from Boise]." Another physician's progress note, dated 2/17/12 at 2:21 PM stated, "This morning he was noted to be confused and possibly hallucinating." The note later stated, "If the patient's mental status does not clear, will consult neuropsychiatry for more thorough evaluation for possible cognitive defects. I do not feel comfortable discharging him home as he still remains disoriented."	A 817		

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A 817	Continued From page 109 A "Case Management" note, dated 2/06/12 at 2:33 PM, stated Patient #2 was single and his home city was [town 9 miles from Boise]. On 2/07/12 at 11:56 AM, a "Case Management" note stated "Pt is apparently married." The name of his wife was listed, along with her phone number. A "Case Management" note, dated 2/13/12 at 2:49 PM, stated Patient #2 required assistance with mobility and ADLs. The next "Case Management" note that mentioned his living situation was dated 2/14/12 at 2:47 PM. The note stated Patient #2 lived with his wife in [town 270 miles from Boise]. A "Social Work" note, entered on 2/14/12 at 3:03 PM, stated Patient #2 lived in [town 9 miles from Boise]. A "Case Management" note dated 2/15/12 at 10:51 AM stated "Anticipated pt will dc to inlaws home in [town 106 miles from Boise] area. I scheduled new pt appt at the [Clinic name] in [town 270 miles from Boise]...." A physician's "Progress Note," dated 2/18/12 at 11:53 AM, stated, "The patient's social situation is tenuous as his wife is young and working fulltime and they have a 1-year old son at home, not a lot of social support. He has no primary care physician established in [town 270 miles from Boise]. I do not feel the patient is yet safe to send home." A discharge plan was not found in Patient #2's record. The location and residence Patient #2 was discharged to could not be found in Patient #2's record. Without knowing where Patient #2 was discharged to, his access to community services could not be verified.	A 817		

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A 817	Continued From page 110 The Assistant Director of Case Management was interviewed on 4/26/12 at 9:15 AM. She reviewed Patient #2's record and was unable to confirm where Patient #2 went after discharge; to his in-law's home or with his wife. The Assistant Director was unable to identify Patient #2's primary place of residence. She could not identify a discharge plan. The facility failed to provide a thorough discharge plan for Patient #2. 2. Patient #1's medical record documented a 47 year old female who was admitted to the hospital on 1/30/12. The "History and Physical," dated 1/30/12 at 6:20 PM, stated Patient #1 came from a residential alcohol treatment center where she "...became increasingly agitated with an altered level of consciousness." The note stated she was obtunded (mentally dulled). Patient #1's date and time of discharge were not documented. The identifying information on Patient #1's "Discharge Summary," dated 2/10/12 at 10:21 PM, stated she was discharged on 2/09/12. The body of the "Discharge Summary" stated Patient #1 was discharged on 2/10/12 to her parents' home. However, the medical record stopped on 2/09/12. The last physician order, dated 2/09/12 at 2:52 PM, stated to discharge Patient #1. It did not say where to. The last documented medication given was dated 2/09/12 at 2:30 PM. The last nursing note was a "Direct Charting Flowsheet, dated 2/09/12 at 3:32 PM. It stated Patient #1's IV was discontinued. No progress note by nursing, by social services, or by the Case Manager was present in the record stating the date and time Patient #1 was	A 817		

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A 817	Continued From page 111 discharged or where she was discharged to. Patient #1's "Direct Charting Flowsheet," dated 2/09/12 at 12:00 noon, stated she had short term memory loss, garbled speech, and was only able to follow 1 step commands. "Restraint Non-violent Forms" documented Patient #1 was restrained from 1/30/12 to 2/07/12. A "Case Management Assessment," dated 2/01/12 at 4:03 PM, stated Patient #1 lived in a house, was ambulatory, and was independent. The assessment stated Patient #1 had no insurance coverage and no prescription coverage. It stated substance abuse treatment was arranged and said Patient #1's initial plan was "home." The "Case Management Assessment" did not include a specific discharge plan. The next and final documented "Case Management" note was dated 2/08/12 at 3:48 PM. It stated Patient #1 had been receiving intermittent doses of antipsychotic medication and anti-anxiety medication. It stated Patient #1 was not appropriate for treatment at an alcohol rehabilitation facility. It stated the physician had requested a meeting with Patient #1's parents to discuss discharge. A discharge plan was not documented in Case Management notes. Social work notes were documented on 1/31/12, 2/01/12, 2/02/12, 2/03/12, 2/06/12, and 2/07/12. A social work note, dated 2/02/12 at 3:17 PM, stated Patient #1 could go to a residential alcohol treatment center when she was medically cleared. The note stated she was "...not medically cleared yet. Attempted to meet with pt.	A 817		

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A 817	Continued From page 112 she is disoriented, in restraints. Will follow when mentally clear to discuss plan." A complete discharge plan, including an alternative based on Patient #1's medical condition, was not developed. The final social work note, on 2/07/12 at 11:35 AM, stated Patient #1 was still in restraints and her mental status was "not clearing." The note stated Patient #1 was not a candidate to return to the alcohol treatment center she came from. The Case Manager for Patient #1 reviewed the medical record and was interviewed on 4/24/12 beginning at 11:07 AM. She confirmed a discharge plan was not documented for Patient #1. She stated the initial plan was to send Patient #1 to a residential alcohol treatment program. She stated it was determined Patient #1 was not medically appropriate for that program. She stated she thought Patient #1 was discharged with her parents but she said she was not certain of this. She could not say whether Patient #1 was discharged to her own home or to her parents' home. The Social Worker joined the interview with the Case Manager at 11:20 PM. They stated they thought Patient #1 was going to the residential alcohol treatment program. They stated all of a sudden Patient #1 was gone and they were "out of the loop" regarding what happened to her. A discharge plan was not developed for Patient #1. 3. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. The "ED Physician Notes," dated	A 817		

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A 817	Continued From page 113 3/12/12 at 10:12 PM, stated Patient #3 had a history of schizophrenia and dementia. He was admitted for combative behavior. There were 33 Case Management notes documented in the medical record between 3/13/12 and 4/18/12. A "Case Management Form," dated 3/14/12 at 9:04 AM, stated Patient #3 had come from a long term care facility and they would not accept him back. Numerous notes documented contacts and discussions with at least 12 long term care providers and Patient #3's POA. However, a document that could be identified as a discharge plan, including barriers to discharge and strategies to overcome those barriers, was not present in the medical record. The Case Manager and Social Worker were interviewed together on 4/25/12 beginning at 1:55 PM. They stated Patient #3 was still an inpatient because of discharge planning problems. They were not able to identify a discharge plan in the medical record. A discharge plan was not developed for Patient #3. 4. The hospital policy, "DISCHARGE PLANNING", revised 11/10, did not specify what discharge plans included and how they were to be documented. The only reference to discharge plans in the policy occurred under section V. It stated "All staff are expected to read and be familiar with the documentation and plans of other disciplines." The term "discharge plan" was not mentioned or defined. The Assistant Director for Case Management	A 817		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130007	A. BUILDING _____ B. WING _____	C 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTER	1055 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 817	Continued From page 114 was interviewed on 4/26/12 beginning at 8:55 AM. She confirmed the hospital had not specified a document that could be identified as a discharge plan or how discharge plans could be identified. The hospital had not developed a process to document discharge plans.	A 817		
A 821	482.43(c)(4) REASSESSMENT OF A DISCHARGE PLAN The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure the discharge plan was reassessed as the patient's discharge planning needs changed for 1 of 4 discharged patients (Patient #1) whose medical records were reviewed. This prevented the hospital from developing new plans in response to changing discharge planning needs. Findings include: Patient #1's medical record documented a 47 year old female who was admitted to the hospital on 1/30/12. The "History and Physical," dated 1/30/12 at 6:20 PM, stated Patient #1 came from a residential alcohol treatment center where she "...became increasingly agitated with an altered level of consciousness." The note stated she was obtunded (mentally dulled). Patient #1's date and time of discharge were not documented. The identifying information on Patient #1's "Discharge Summary," dated 2/10/12	A 821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130007	A. BUILDING _____ B. WING _____	C 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTER	1055 NORTH CURTIS ROAD BOISE, ID 83706

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A 821	Continued From page 115	A 821		

at 10:21 PM, stated she was discharged on 2/09/12. The body of the "Discharge Summary" stated Patient #1 was discharged on 2/10/12 to her parents' home. However, the medical record stopped on 2/09/12. No progress note by nursing, by social services, or by the Case Manager was present in the record stating the date and time Patient #1 was discharged or where she was discharged to.

Patient #1's "Direct Charting Flowsheet," dated 2/09/12 at 12:00 noon, stated she had short term memory loss, garbled speech, and was only able to follow 1 step commands. "Restraint Non-violent Forms" documented Patient #1 was restrained from 1/30/12 to 2/07/12.

A "Case Management Assessment," dated 2/01/12 at 4:03 PM, stated Patient #1 lived in a house, was ambulatory, and was independent. The assessment stated Patient #1 had no insurance coverage and no prescription coverage. It stated "Community Resources" were arranged but it did not identify those resources. It said Patient #1's initial plan was "home." It did not include the possibility of Patient #1 returning to the residential treatment center she came from. The "Case Management Assessment" did not include a specific discharge plan.

The next and final documented "Case Management" progress note was dated 2/08/12 at 3:48 PM. It stated Patient #1 had been receiving intermittent doses of antipsychotic medication and anti-anxiety medication. It stated Patient #1 was not appropriate for treatment at a residential alcohol treatment facility. It stated the physician had requested a meeting with Patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130007	A. BUILDING _____ B. WING _____	C 05/01/2012

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A 821	Continued From page 116 #1's parents to discuss discharge. A discharge plan was not documented in Case Management notes. Social work notes were documented on 1/31/12, 2/01/12, 2/02/12, 2/03/12, 2/06/12, and 2/07/12. A social work note, dated 2/02/12 at 3:17 PM, stated Patient #1 could go to a residential alcohol treatment center when she was medically cleared. The note stated she was "...not medically cleared yet. Attempted to meet with pt. she is disoriented, in restraints. Will follow when mentally clear to discuss plan." A complete discharge plan, including an alternative based on Patient #1's medical condition, was not developed. The final note, on 2/07/12 at 11:35 AM, stated Patient #1 was still in restraints and her mental status was "not clearing." The note stated Patient #1 was not a candidate to return to the alcohol treatment center she came from. A discharge plan was not developed to locate other services and residential options for Patient #1, when it became known she was not a candidate for a residential alcohol treatment program. The Case Manger for Patient #1 reviewed the medical record and was interviewed on 4/24/12 beginning at 11:07 AM. She confirmed a discharge plan was not documented for Patient #1. However, she stated the initial plan was to send Patient #1 to a residential alcohol treatment program. She stated it was eventually determined Patient #1 was not medically appropriate for that program due to her confusion and her inability to care for herself. She confirmed further assessment of discharge planning needs and another discharge plan were not documented.	A 821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 821	Continued From page 117 The Case Manger stated she thought Patient #1 was discharged with her parents but she said she was not certain of this. She could not say whether Patient #1 was discharged to her own home or to her parents' home. She could not say whether supervision was available for Patient #1 after discharge. The Social Worker joined the interview with the Case Manager at 11:20 PM. They stated they initially thought Patient #1 was going to the residential alcohol treatment program. They stated all of a sudden Patient #1 was gone and they were "out of the loop" regarding what happened to her. Patient #1's discharge plan was not reassessed after placement in a residential alcohol treatment program fell through.	A 821		

Saint Alphonsus

June 15, 2012

Sylvia Creswell
Idaho Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

Dear Ms. Creswell:

Attached please find Saint Alphonsus Regional Medical Center's plan of correction (POC), which is intended to address deficiencies cited during a complaint investigation concluded on May 1, 2012.

The hospital does not admit or concede to any deficiencies, but to the extent that any actual deficiencies do exist, Saint Alphonsus Regional Medical Center is taking appropriate action to correct those deficiencies, including the steps outlined in the attached POC. This plan of correction addresses the Bureau of Facility Standards tags BB283 and BB461 and Medicare tags A115, A164, A166, A168, A174, A185, A187, A188, A431, A449, A450, A799, A806, A808, A809, A817, and A821.

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. We appreciate your thoughtful consideration of this plan of correction. We look forward to your acceptance of our plan and the revisit to verify our compliance. Please contact me at 367-2902, if you have any questions or concerns regarding these documents.

Respectfully submitted,

Aline Lee

Aline Lee, RN
Director of Patient Safety, Regulatory Compliance, and Infection Prevention
Saint Alphonsus Health System

1055 North Curtis Road
Boise, Idaho 83706-1309
Phone: (208) 367-2121
www.saintalphonsus.org

Federal Survey Plan of Correction
Saint Alphonsus Regional Medical Center
Complaint Survey Concluded May 1, 2012

Tag	Plan of Correction	Completion Date
A115 A hospital must protect and promote each patient's rights.	The Chief Nursing Officer is responsible for the implementation of the corrective action plan regarding restraint. Saint Alphonsus Regional Medical Center (SARMC), a member of the Trinity Health System, uses a computerized documentation system called Powerchart. Powerchart is a Cerner product that is used by 35 of the 40+ hospitals in the Trinity Health System. Powerchart, along with most computerized documentation systems, utilizes pick lists from which the care provider can choose the most appropriate sentence/phrase to describe the assessment of the patient or intervention(s) provided. Pick lists support consistency and efficiency in documentation. Changes to the pick lists in Powerchart can only be made at the Health System level, as the changes affect all hospitals in the system. SARMC's mid-range plan is to work with Health System leaders to recommend changes in the Powerchart pick lists to make the wording more specific e.g. to describe in more detail the behavior necessitating the use of restraints. In the short term, our corrective actions are focused on training nursing staff to better understand the existing system and to provide more detailed documentation through free text in addition to use of the pick lists. An on-line, computerized education module (e-learning) was developed. See Attachment A. The module was assigned to approximately 500 nurses on 5/12/12 to be completed by 6/15/12. The module covers the following topics: • (A164) Alternatives to Restraints Attempted—how to add a note (free text) to describe the alternative intervention attempted, when it was attempted and its effectiveness • (A166) The appropriate plan of care template to select in Powerchart when restraints are initiated, how to individualize it for the patient, when and how to revise the plan of care when the needs of the patient change. • (A168) The regulations regarding LIP orders for restraint, timing and frequency of orders for non-violent and violent restraints, that specific orders are required for each type of restraint, and how to select multiple restraints in Powerchart. • (A174) Discontinuing restraints as soon as possible and when less restrictive measures are effective; how to add free text to document detail on the rationale for removing restraints, the less restrictive measures used and their effectiveness. • (A185 and A187) When restraints are initiated, how to add free text to document the patient's specific observed behaviors necessitating the use of restraint, the specific type of restraint used, and the actual time the restraint was applied.	7/13/12

Tag	Plan of Correction	Completion Date
	• (A188) How to add free text to describe the patient's behavior necessitating the continuing use of restraints and response to restraints. The e-learning module includes a post-test. Completion of the module is being tracked and reported back to the managers. To reinforce the training, name badge cards and checklist notepads have been created to provide a quick reference for nursing staff on the restraint requirements. To reinforce the training and monitor progress, a comprehensive audit tool was developed. Attachment B. Nurses who work with patients in restraint are expected to complete one audit by 7/13/12. Subsequently, auditing of restraints will continue on a quarterly basis. The results of the restraint audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A115.	
A164 Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.	Please refer to tag A115.	
A166 The use of restraint or seclusion must be in accordance with a written modification to the patient's plan of care.	Please refer to tag A115.	

Tag	Plan of Correction	Completion Date
A168 The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law.	Please refer to tag A115.	
A174 Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.	Please refer to tag A115.	
A185 There must be documentation in the patient's medical record of the following: A description of the patient's behavior and the interventions use.	Please refer to tag A115.	
A187 There must be documentation in the patient's medical record of the following: The patient's condition or symptom(s) that warranted the use of the restraint or seclusion.	Please refer to tag A115.	

Federal Survey Plan of Correction
Saint Alphonsus Regional Medical Center
Complaint Survey Concluded May 1, 2012

Tag	Plan of Correction	Completion Date
A188 There must be documentation in the patient's medical record of the following: The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.	Please refer to tag A115.	
A431 The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.	The Director of Health Information Management is responsible for implementation of the corrective action plan for tags A431, A449, and A450 except for when there is a reference to another tag or another responsible person is identified. The HIM Director developed a policy entitled "Quality Health Record Review Plan". Attachment C. This policy establishes the Director of Health Information Management (HIM) as responsible for the development and oversight of the quality health record plan. HIM coordinates the health record review process for the medical staff. For other clinicians who contribute to the medical record, it is the responsibility of the clinical department manager to identify documentation requirements within the scope of practice for the department, train staff, implement documentation standards, monitor documentation standards, and implement performance improvement plans to correct documentation deficiencies. Audit tools and results are entered into a web-based system so that reports can be pulled centrally. This assures that the HIM Director has access to all data regarding the quality and completeness of the health record. Health record quality data, analyses, performance improvement plans, and progress toward improvement (for the medical staff and other clinical departments) will be reported through the HIM Director to the appropriate organization-wide quality committee(s) for review and accountability on a semi-annual basis.	7/13/12
A449 The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to	The deficiencies cited under this tag relate to documentation in the health record of progress and response to services in three areas: discharge planning, restraint, and the plan of care. Please see tag A799 for a detailed explanation of the actions taken to come into compliance with the discharge planning standards. As described in tag A799, an ongoing auditing process to evaluate discharge planning documentation has been developed. The results of the discharge planning audits will be provided quarterly to the HIM Director for inclusion in the process for overall evaluation of the	7/13/12

Tag	Plan of Correction	Completion Date
medications and services.	medical record as described in tag A431. Please see tag A115 for a detailed explanation of the actions taken to come into compliance with the restraint standards. As described in tag A115, an ongoing auditing process to evaluate use and documentation of restraints has been developed. The results of the restraint audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A115. The plan of correction for documentation of the plan of care is described below under this tag (A449). Plan of Care: The Chief Nursing Officer is responsible for the implementation of the corrective action plan regarding the nursing plan of care. Saint Alphonsus Regional Medical Center (SARMC), a member of the Trinity Health System, uses a computerized documentation system called Powerchart. Powerchart is a Cerner product that is used by 35 of the 40+ hospitals in the Trinity Health System. Powerchart, along with most computerized documentation systems, utilizes care plan templates for specific diagnoses, conditions, or needs. The templates are built to include a list of potential interventions from which the care provider can choose, as appropriate to the patient's needs. In Powerchart, these templates are called Interdisciplinary Plans of Care (IPOC). Changes to the structure and functioning of Powerchart can only be made at the Health System level, as the changes affect all hospitals in the system. SARMC's mid-range plan is to work with Health System leaders to recommend structural and functional changes to Powerchart in order to create a care planning system that better facilitates individualization of the plan to the patient's needs and more clearly documents the patient's progress toward goals. In the short term, the plan of correction is focusing on training of the nursing staff and other disciplines who contribute to the plan of care, to improve the use of the existing IPOCs and ongoing monitoring of the plan of care documentation. Please see Attachment D. More than 500 staff members are required to attend a one hour class in the computer training labs. The class includes didactic training as well as hands-on use of the computer to practice documentation of the IPOC on test patients. The content of the training includes: the importance and purpose of IPOCs; examples of appropriate/inadequate IPOCs; initiating, individualizing, updating, and discontinuing IPOCs; and using the Hand-off Form as an adjunct to the IPOC. The training also included information specific to care planning when a patient is in restraints. The training started 6/5/12 and will be completed by 6/22/12.	

Tag	Plan of Correction	Completion Date
	To reinforce the training and monitor progress, an audit tool was developed. Please see Attachment E. During the class the audit tool was provided to each participant. The expectation was communicated that each participant was to perform one audit by 7/13/12. Subsequently, auditing of IPOCs will continue on a quarterly basis. The results of the IPOC audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A115.	
A450 All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.	The deficiencies cited under this tag relate to the completeness of documentation in the health record in three areas: discharge planning, restraint, and the plan of care. Please see tag A799 for a detailed explanation of the actions taken to come into compliance with the discharge planning standards. As described in tag A799, an ongoing auditing process to evaluate discharge planning documentation has been developed. The results of the discharge planning audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A431. Please see tag A115 for a detailed explanation of the actions taken to come into compliance with the restraint standards. As described in tag A115, an ongoing auditing process to evaluate use and documentation of restraints has been developed. The results of the restraint audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A115. Please see tag A449 for a detailed explanation of the actions taken to improve documentation of the plan of care. As described in tag A449, an ongoing auditing process to evaluate the documentation of the plan of care has been implemented. The results of the plan of care audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A449.	7/13/12
A799 The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be	The Director of Clinical Resource Management and Acute Social Work developed and implemented the plan of correction related to all tags cited under the Discharge Planning Condition of Participation. The Director led a team of Clinical Resource Managers (CRM) and Social Workers (MSW) in developing a written document that delineates discharge planning documentation standards for CRMs and MSWs. The documentation standards were completed on 5/10/12. Please see Attachment F. The documentation standards define the expectations for data collection and documentation in four areas:	7/13/12

Tag	Plan of Correction	Completion Date
specified in writing.	(1) Initial assessment and plan (A806 and A817), (2) Reassessment/re-evaluation (A821), (3) Implementation/ Coordination of Care (A817), and (4) Final discharge plan (A817). Initial Assessment and plan: The documentation standards delineate the information to be collected during the initial assessment (A806) which will be used to create the initial discharge plan (A817). The initial assessment will include, at a minimum: age; diagnosis and circumstances that brought the patient to the hospital; living situation (A809); employment; insurance/financial situation; specific patient needs based upon patient's behaviors and physical/cognitive ability to care for self (A809); and family/other support such as degree of involvement and ability to care for patient (A809). The initial discharge plan will include the likely post-discharge needs and the rationale (A808 and A817). Reassessment and re-evaluation (A821): The documentation standards outline the information to be collected, analyzed, and documented to update the discharge plan. This information includes: changes in patient condition including responses to treatment and/or barriers to discharge (A809); patient behaviors and progress/response to treatment as documented by other team members such as dietitian, therapies, etc.; discussions during interdisciplinary rounds; and information discussed with patient/family (A809). Implementation/Coordination of Care (A817): The documentation standards describe the information to be included in the working discharge plan including: services and referrals that have been set up (contacts, phone numbers, time frames, and why service is needed) (A808); family involvement; insurance coverage/benefits, if applicable; and documentation of patient choice. Final Discharge Plan (A817): The documentation standards outline the information that will be included in the final discharge plan including: discharge location, caregivers and their ability to provide care, and the patient's ability for self-care (A809). The Director of Clinical Resource Management and Acute Social Work provided education to the CRM and MSW staff members on the documentation standards on 5/16/12. A team of CRM and MSW staff members led by the Director developed an audit tool to be used to monitor compliance with the documentation standards. Please see Attachment G. The audit tool addresses each item in the documentation standards. Each CRM and MSW staff member will complete 2 audits per week (a total of about 30 audits/week) through July 2012. The data from the	

Tag	Plan of Correction	Completion Date
	audits will be summarized, analyzed and feedback will be provided to staff members. The audit results will be sent to the Director of Health Information Management to be included in the process for overall evaluation of the medical record. The audits were implemented on 5/28/12. The Director revised the Discharge Planning policy on 5/25/12 to describe the ongoing discharge planning quality monitoring process. Auditing will be conducted on a quarterly basis.	
A806 The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.	Please refer to tag A799.	
A808 The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.	Please refer to tag A799.	

Tag	Plan of Correction	Completion Date
A809 The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.	Please refer to tag A799.	
A817 Discharge Plan	Please refer to tag A799.	
A821 The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.	Please refer to tag A799.	

Attachment A

Patients in Restraint: Does your Documentation "Tell the Story?"

SARMC

Spring 2012 (updated 6/5/2012)

Saint Alphonsus

Questions about Restraint Use or Documentation?

- **Contact Cara Nissen (caranissen@sarmc.org)**
- Ask your charge nurse or manager
- Call 5448 (documentation questions)
- Call the Clinical Coordinator (restraint use questions)

Non-Violent vs. Violent Restraint

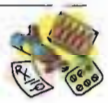
- **Non-Violent Restraint**
  - Used for acute medical or surgical care which supports the physical health and safety *of the patient*.
- **Violent Restraint**
  - Restraints used to manage behavior that jeopardizes the *immediate safety of the patient, staff or others,* regardless of the type of restraints used.
  - **If the patient is attempting to harm themselves, staff, visitors, or other patients, it is considered a Violent Restraint!**

Non-Violent vs. Violent Restraint

- **Non-Violent Restraint** should always have:
  - **Non-Violent Order**
  - **Non-Violent forms**
- **Violent Restraint** should always have
  - **Violent Order**
  - **Violent forms**

Charts that are reviewed often have Violent forms filled out when a Non-Violent order is placed (or vice versa). Make sure the forms and order types match.

Chemical Restraint



- **Definition:** The use of a medication to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
- Chemical Restraint is NOT permitted or used at SARMC.
- A PRN or one-time medication prescribed to control a behavior resulting from a condition is **not** considered Chemical Restraint if the **standard dosage is used for that condition** (i.e. haloperidol used for acute psychosis).

Patient Safety and Rights

- While the use of restraint to keep a patient safe is sometimes necessary, this decision should never be taken lightly, and the use of restraint should be documented carefully.

Patient Safety and Rights

- Restraints may only be imposed to ensure the immediate physical safety of a patient or other person.
- The decision to use restraint is not driven by diagnosis, but by a comprehensive, individualized patient assessment.
- When a patient is in restraint, the nurse should continuously be evaluating the situation to determine if restraints can be safely discontinued.

Restraint Orders

- Restraints may not be used on a PRN basis, except in special circumstances (see policy).
- Each restraint order should correspond with a specific incident of applying restraint.
- If the LIP orders restraints that are not utilized, *another order* is required if restraints are needed later in the day.
- If you discontinue restraints and then need to reapply them, *a new order is needed!*

Surveyors recently found restraints discontinued and then restarted without a new order.

Non-Violent Restraint Orders

- Restraint Orders must be obtained either prior to restraint placement or *as soon as possible* thereafter.
  - If you delay obtaining a new order for any reason (i.e. over an hour), document the reason in the medical record (Nursing Progress Note).
  - An initial order must be obtained prior to the end of your shift.

If there is a delay of several hours between restraint placement and obtaining an order, surveyors will want to know why.

Non-Violent Restraint Orders

- Non-Violent Restraints must be re-ordered every calendar day a patient is continuously in restraint per policy (not every 24 hours).
- If the restraint is discontinued, *you still need a new order for that calendar day.*
- Remind the LIP to re-order the restraint!!!

Surveyors found restraints documented without orders for every day. Many of the missing orders were on the last day the patient was in restraint.

Violent Restraint Orders

- **Violent Restraint** orders must be obtained *within one hour.* A new order must be obtained every 4 hours for adults (more frequently for pediatric patients—see Restraint and Seclusion policy)
- A restraint order must be obtained whenever a patient is restrained, even for only a minute.
- Physically holding a patient for medication administration or to prevent elopement is considered Violent Restraint!
  - Restraint Type in PowerChart is "Therapeutic Hold"

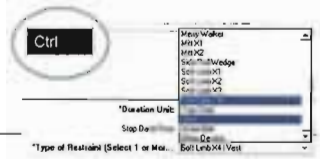
Verbal/Phone orders

- If a phone or verbal order is obtained **from the LIP** for restraint, make sure it is entered as a phone or verbal order.
- **Never enter restraint orders as Written, Nursing Intervention, Protocol, or Department.**

Restraint: Specific Orders

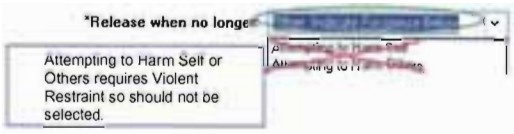
- A specific order is needed for each type of restraint used.
  - i.e. Five-point restraint requires an order for **Soft Limb X4** and **Vest** restraints.
- In Powerchart, hold the **Ctrl key** down to add multiple options within the same PowerPlan:

Surveyors found restraint orders that did not include all types of restraint used.



Order Detail: Release when no longer…

- Always choose "**Other: Indicate Response Below**" for Non-Violent Restraint.



Attempting to Harm Self or Others requires Violent Restraint so should not be selected.

- **Reason for releasing restraint should be free text entered**.

Additional Instructions/Comments: No longer pulling tubes

Restraint Documentation

- The **Restraint Non-Violent** form or **Restraint/Seclusion Violent** form in PowerChart needs to be completed upon
  - **Initiation**
  - **Discontinuation**
  - **Assessments**
    - Every 2 hours for Non-Violent
    - Every 15 minutes for Violent

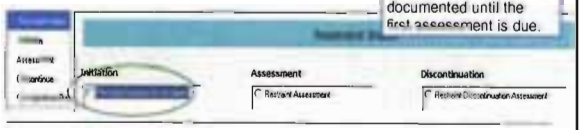
Nearly every chart the surveyors reviewed had missing initiation, assessments, and/or discontinuation assessments.

- Make sure you are documenting in the correct section!

Restraint Initiation

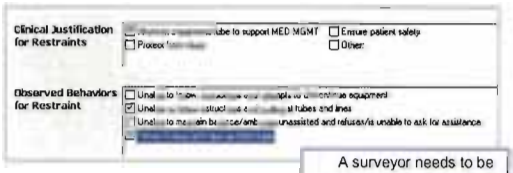
- Obtain the first Restraint (Non-Violent or Violent) form from **AdHoc**.
- Document the **exact time** restraints were applied. Do not wait to document Initiation until the first form fires to Activities & Interventions.

Initiation documentation is often missing, or isn't documented until the first assessment is due.



Restraint Initiation

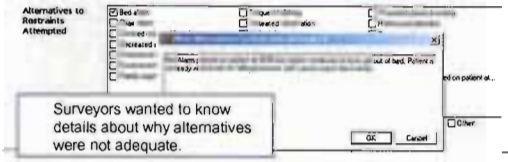
- In the Initiation section, free text the specific Observed Behavior in the "Other" section.



A surveyor needs to be able to tell which tube, line, or equipment was involved.

Alternatives to Restraints Attempted

- Document "Alternatives to Restraints Attempted".
- Select "Other" to add a note to describe the intervention, when it was attempted, and its effectiveness (why it didn't work).



Surveyors wanted to know details about why alternatives were not adequate.

Alternatives to Restraints Attempted

- Make sure Less Restrictive Alternatives documented by the LIP match any Alternatives documented in the Restraint Form.

Surveyors found that Less Restrictive Alternatives in the Order did not always match nursing documentation.

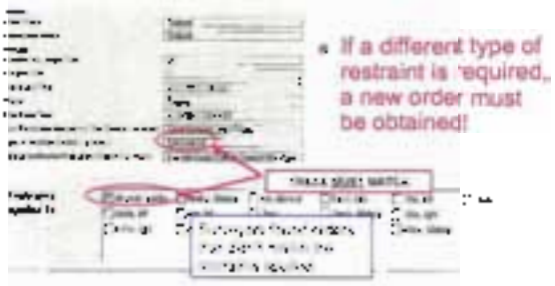
Alternatives to Restraints Attempted

- **Only** document "Alternatives to Restraints Attempted" if restraints are *not on the patient.*
- **Do not** document Alternatives in the Assessment section (only Initiation).
- If alternatives are attempted after restraints have been initiated, ***a new order is required if the alternative is unsuccessful!***

Surveyors assume that restraints are off the patient (discontinued) if an alternative is attempted.

Restraint Type Documentation

- Make sure the type of restraint indicated in the Initiation section *matches the order*



Restraint Type Documentation

Restraint Assessments

- Non-Violent Restraint Assessments are completed every 2 hours (unless there is Activities & Interventions on the even hours)
- Violent Restraint Assessments are completed every 15 minutes on the **Restraint/Seclusion Violent** form (must Add/Loc for Violent Restraint assessments)
- Complete ALL sections of the Assessment form each time you complete it

Cares for Patients in Restraint

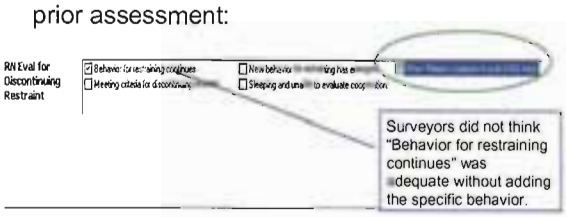
- Offer or provide nutrition/hydration, hygiene and toileting, and range of motion **every 2 hours** as appropriate for that patient.

Face-to-Face Assessment (Violent only)

- Always complete Initiation AND at least one Assessment section for Violent Restraint, even if restraint placed for only a moment:

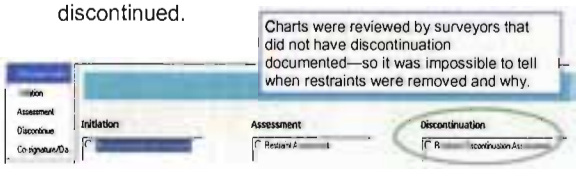
Continuing Restraint

- **Free text** the patient's **specific behavior** that requires restraint with each assessment, even if unchanged from the prior assessment:



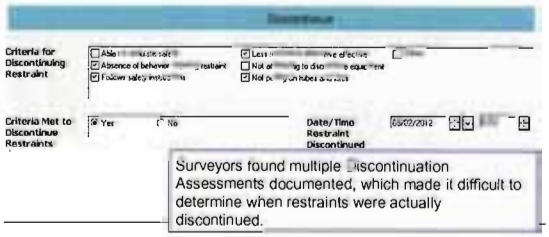
Discontinuing Restraint

- Discontinue restraints as soon as possible, when less restrictive measures are effective to keep the patient safe.
  - You do not need an LIP order to discontinue restraints.
  - Document the *exact* time restraints are discontinued.



Discontinuing Restraint

- Document the reason that restraints were able to be discontinued (behavior of the patient) .
- Once restraints have been discontinued and documented, *do not complete additional Restraint forms.*



Discontinuing Restraint

If Less Restrictive Alternatives are effective when restraints are discontinued, add details in the Discontinue section under "Other" to describe what the alternative measure is.

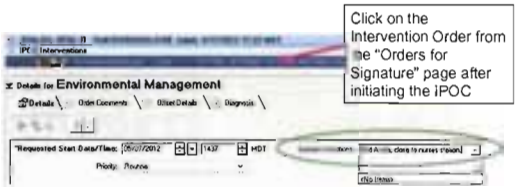
Plan of Care Update

- **Risk of Injury to Self/Others** IPOC is ALWAYS initiated for Non-Violent or Violent Restraint.
  - Located under "Suggested Plans" once the Restraint order is placed
- Document **specific interventions** used to keep the patient safe.
- Update the IPOC once restraints are discontinued (**change the interventions to include less restrictive measures used to keep the patient safe**).

Surveyors found patients that had been in restraint with no Risk of Injury IPOC initiated, or options selected were not specific enough.

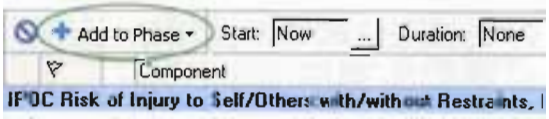
Individualizing the Plan of Care

- To individualize an IPOC, free text Special Instructions in Order Details:



Individualizing the Plan of Care

- You may individualize any IPOC by adding a "Communication Order" by clicking Add to Phase.



Attachment B

Date:__/__/____ Setting:_____ YOUR NAME (Only if completing on Paper):_____ Entered By:_____ Staff Member_____

Reason for Audit: LEAVE "ENTERED BY" AND "STAFF MEMBER" FIELDS BLANK IF COMPLETING ON PAPER.

The purpose of this Nursing Chart Audit Tool is to audit charts of patients in restraint for compliance with restraint documentation.

Instructions: Each nurse should review the chart of a patient that is currently, or has been, in restraints. If there is not a patient in restraint on your unit, you may ask your manager or charge nurse for the name of a patient on another unit that has been in restraints (refer to Patient Daily List or Non-Violent or Violent Restraint Report).
Review the past 3 days of restraint documentation, unless otherwise indicated in the question.
Fax to Diane Johnson (8181). Questions? Contact Cara Nissen (caraniss@sarmc.org)

** Indicates that an answer is required.*

Restraint Audit 2012 (June and July)

Information	Answer	Comments
1.Are you completing this audit on paper? If so, did you clearly write: 1) Your name 2) Setting (unit) the patient is on (if completing audit online, indicate NA)	Yes | No | NA	
2.* Is your unit/department the same as the unit that the patient is/was on? If not, enter YOUR unit in this comment box (includes CST). Enter the setting that the patient is/was on under Setting. If the patient was on more than one unit, enter the last unit the patient was on.	Yes | No	*YOUR UNIT*
3.What is the patient's FIN#?	Yes | No | NA	*FIN #*
4.What are the dates you are auditing? (Last 3 days of documentation for Restraint audit and Admission to present for IPOC/Other Audit)	Yes | No | NA	
Restraint Documentation	**Answer**	**Comments**
5.* Check the first documented Restraint form in Forms Review. Is the Initiation section completed?	Yes | No	
6.Check the Initiation documentation (if present). Does the Restraint Non-Violent form time match the "Date/Time Restraint Applied" time? (If there is not an Initiation form documented, indicate NA)	Yes | No | NA	
7.* By reviewing documentation in the patient's chart, can you determine what specific behavior of the patient led to the use of restraint? (Check Restraint Initiation section, Handoff forms, Nursing Progress Notes, Significant Event Forms, etc.	Yes | No	
8.Are all initial restraint orders placed within an hour of restraint initiation? (Check Forms Review and Orders)	Yes | No | NA	
9.IF there is a delay of more than an hour between restraint initiation and the initial restraint order...is the reason for delay in obtaining the order documented? (Restraint Form, Handoff Form, or other location)	Yes | No | NA	
10.Does the type of Restraint order (Non-Violent vs. Violent) match the patient's behavior? Non-Violent restraint is used to support acute medical or surgical care which supports the health and safety of the patient. Violent restraint is used to manage behavior of a patient that jeopardizes the immediate safety of the patient, staff, or others. If the patient is trying to hurt themselves, staff, visitors, or other patients, it is considered Violent restraint.	Yes | No | NA	
11.* Right-click on Restraint orders and select Order Information. If any restraint orders are entered by the RN, are they entered as phone or verbal orders? (check last 3 days) (should not be entered by RN as written, protocol, nursing intervention, or department order)	Yes | No	
12.Are the types of restraint indicated in the Order details the same as the types of restraint documented on the Restraint form? (This documentation is found only in the Restraint form Initiation section. There should be an Initiation section completed with the first restraint form, and whenever the restraint types change)	Yes | No | NA	

13.Do "Less Restrictive Alternatives Tried" in the Orders match "Alternatives to Restraint Attempted" in the Restraint Forms?	Yes | No | NA	
14.For each alternative to restraint attempted, is there documentation indicating WHEN the measure was attempted, WHY the measure didn't work, and a detailed DESCRIPTION of the alternative intervention?	Yes | No | NA	
15.In the Restraint Forms, if there are documented "Alternatives to Restraint Attempted" in any Assessment sections after restraints have been initiated, is there a new restraint order obtained if the alternative was unsuccessful?	Yes | No | NA	
16.* In the Order details for each Restraint order: Does the "Release when no longer" field show: "Other: Indicate Response Below?"	Yes | No	
17.If "Other: Indicate Response Below" is indicated under "Release when no longer:" is there a reason free texted into the Additional Instructions/Comments section? If "Attempting to Harm Self" of "Attempting to Harm Others" is indicated, choose NA.	Yes | No | NA	
18.* Review the Restraint Orders and the Restraint Forms (up to 3 days). Is there a restraint order in place for every day the patient is in restraint, including the last day (if applicable)? (There should be an order for each day Restraint Forms are completed in Forms Review)	Yes | No	
19.* Is there an assessment documented every 2 hours the patient was in restraint? If there are gaps, check for discontinuation assessments. If there is not a discontinuation assessment, gaps should be counted as missed assessments.	Yes | No	
20.Is each Restraint Assessment section completely filled out every 2 hours, including Nutrition/Hydration, Hygiene/Elimination, and ROM/Positioning? (Check individual Restraint Non-Violent forms in Forms Review, or Results Review for this information)	Yes | No | NA	
21.Check the "RN Eval for Discontinuing Restraint" field in the Restraint Assessment section. Is the patient's specific behavior documented with each Restraint assessment? (should be free texted under "Other")	Yes | No | NA	
22.If Restraint Assessments do not indicate the patient's specific behavior for continuing restraint, is there clear documentation elsewhere indicating the patient's specific behavior that required the use of restraint? (Check Handoff forms, Nursing Progress Notes, Psychosocial Assessment in IView, etc. The documentation should indicate specific behaviors, tubes, etc.)	Yes | No | NA	
23.If there is a gap of longer than 2 hours in completed Restraint forms in Forms Review, is there an order that corresponds with the first Restraint form completed after any gap? (For example, if restraint forms are present every 2 hours until 1200...then there is a gap until 2000...is there an order at 2000?) If there is not a Restraint form documented every 2 hours, it indicates that restraints were not on the patient (discontinued). If restraints begin again, there should be a new order.	Yes | No | NA	
24.If there is a gap of longer than 2 hours in completed Restraint forms, is there an Initiation section completed after the gap?	Yes | No | NA	
25.If the patient is not currently in restraint, or if there are gaps in the 2 hour assessments in Forms Review, is there a Discontinuation section completed indicating the exact time the restraints were discontinued?	Yes | No | NA	
26.If Restraints were discontinued, does the documentation indicate the reason that restraints were able to be discontinued? (behavior of the patient)	Yes | No | NA	
27.Was there a Risk of Injury to Self/Others IPOC initiated after restraints were placed on a patient? (by the end of the nurse's shift)	Yes | No | NA	
28.Does the Risk of Injury to Self/Others IPOC indicate specific Interventions used to keep the patient safe? (Will appear in Orders section under "IPOC Interventions", or under Patient Care orders as a "Communication Order")	Yes | No | NA	
29.If restraints were discontinued, was the Plan of Care updated to include new interventions to keep the patient safe without restraint? (Could be indicated in the Risk of Injury IPOC, in a different IPOC, or in a Handoff Form)	Yes | No | NA	

Attachment C

Saint Alphonsus

Administrative

06/15/2012

Title: Quality Health Record Review Plan

Policy Statement:
Saint Alphonsus Regional Medical Center, including Saint Alphonsus Medical Group, reviews the patient health record for accuracy, timeliness, completeness and legibility.

Procedure:

I. The Director of Health Information Management is responsible for the development and oversight of the medical center's Quality Health Record Review plan. The plan is designed to ensure that the record contains information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

II. The Health Information Management Department analyzes charts for the presence of provider and clinician documentation necessary for a complete medical record.

III. Each clinical department responsible providing care and services will be responsible to:
   A. Identify documentation requirements within their scope of service, train staff and implement departmental documentation standards.
   B. Monitor staff compliance with documentation standards through regular health record audits.
   C. When necessary, implement performance improvement plans to correct any documentation deficiencies identified through monitoring or audit activities.

IV. V Survey is the recommended audit tool for all health record review activity for consistency in tracking and reporting.
   A. If V-survey is not used, the department manager is responsible to report audit results to Director of HIM.
   B. The Accreditation Specialist provides V-Survey support by setting up the audit tools, creating, running and distributing reports.

V. Health Record Review activity for medical staff will be coordinated by HIM and reported to the QHR Documentation Team of the medical staff for review and recommendations for action.

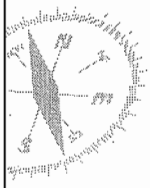
VI. Clinical Informatics Department provides training support for documentation process in the electronic health record.

VII. Health Record Review activity for departments of the medical center will be reported to the Boise UCO Ministry Team by HIM Director semi-annually, as established by the Committee.

Related Policies:
Health Record Form and Content

Attachment D

CMS Survey Follow Up



5 Charts Later

Why this is so important

- **The chart is the true record of the patient's care**
- If your documentation is not clearly spelled out in the chart, nobody can see the care you provided.
- Think back 6 months ago...
  - Think of the care you provided to 3 different patients
  - What did you do? What did they do? How did you communicate to others that any of this occurred?
- This is what a surveyor does...

The Story of the IPOCs

- A patient did not have updated IPOCs with documentation for 4 straight days.
- A patient did not have any interventions selected in the IPOC.
- "Anxiety Counseling" selected as an IPOC intervention, but the staff were not able to explain what this meant.

Tell the Story: IPOCs

A nursing care plan is based on assessing the patient's nursing care needs and developing appropriate nursing interventions in response to those needs. The nursing care plan is kept current with updates according to ongoing assessments of the patient's needs, and response to interventions.

IPOC Goals: Have an outlined and documented plan for how to achieve a patient's goals and the patient's progress in achieving these goals.

- Individualized and meaningful for each patient.
- The most important issues for a patient represented.

IPOC Documentation Expectations

- Initiated by the admitting nurse
  - Data in your IPOCs only flows from your charting after the IPOC has been opened
- Meaningfully updated at least every 12 hour shift, based on patient assessment and progress

The Story of the Missing Communication

- A patient who required the staff speak slowly to avoid over stimulation, did not have this written anywhere the chart.
  - Instead, the staff had verbally communicated this with each other.
- When an handoff form was completed, it often was not signed by the oncoming nurse for 6-8 hours.
- Patients transferred to other unit with no documentation about time of transfer.
- There was no one place to consistently find a summary of events for a patient.
- **This is how we should use the Hand Off form**

Document in the Handoff Form

- In the anticipated events section of the Handoff Form, nursing should document an **end of shift summary.**
- An end of shift summary is a brief summary of the most important information to communicate to the next shift.
  - **Important events** of your shift.
  - **Tips and tricks** for this patient's care.
  - **Expected (anticipated) events** for the next shift
- The handoff form pulls forward this information from shift to shift for easy review.
- Review with oncoming nurse during shift to shift bedside handoff

Example Important Events

- Fall
- Blood product
- Procedures
- MRT/Code
- Isolation Precautions
- Interpreter/ Interpreter line (blue phone) use and schedule
- Remote Telemetry
- Restraints
- Self harm behavior
- Increased oxygen demands
- Drip titration
- Critical results
- Unique events specific to your care area

Examples of Tips & Tricks

- Always speak slowly to this patient to reduce the likelihood of aggressive behavior.
- Keep Coban wrapped around the IV to prevent it from being pulled out.
- Watch foley, it will need to be emptied frequently.

Examples of Expected Events

- Labs; include serial labs
  - Every 6hr Troponins or every 4hr H&Hs
  - Peaks and Troughs for Vancomycin
- Planned
  - Procedure
  - Imaging studies
  - Family conference
  - Transport dates for psychiatrically committed patients
- Future administrations like blood products or chemotherapy

The Story of Missing Standard Documentation

- Diabetic patient with no meals documented for 3 days
- No oral care or hygiene documented on patients
- No activities/range of motion/oral care or elimination needs documented for a patient in restraints all day
- A patient's ambulation not documented on for multiple days
- Incontinent patient with no peri-care documented
- Bed rest patient with no repositioning documented
- Patients discharged with no documentation about time of discharge or where the patient went.

Standard Documentation

Performed or observed interventions need to be documented

- Meals/snacks/intake
  - At least 3 times a day
  - If patient doesn't eat, document refused
  - If patient NPO, document under meal type at least once a shift
- Hygiene
  - Oral care twice daily,
  - Oral care on the unconscious, debilitated or intubated patient at a minimum every four hours, if not more frequently.
  - Daily bath/shower/cares
  - Peri-care with episodes of incontinence
- Ambulation
  - Anytime a patient gets out of bed
  - Including walking in hall, going to bathroom/commode, sitting in a chair
- Turning
  - Every 2 hours; document a change in patient's position
  - Positioned on right side, left side, or supine.

Adhoc Forms

Certain events require the completion of an *adhoc* form.

- Complete ALL fields within these forms (unless not applicable).
  - More than just the yellow required fields
  - Fully describe the event in various fields of the form
- Add details in your description to tell the story of the event.

Examples of Adhoc Forms:

- Discharge/Depart Form
- Post Fall Assessment Form
- Critical Result/Test/Other Notify Form
- Expiration Note Form

The Story of Restraints

- A patient was put in restraints without an order for 5 hours.
- A restrained patient was documented in iView as being alert, oriented x4, and appropriate for multiple shifts and days.

Restraints

- Have you completed the restraint documentation in e-learning?
- It was assigned and due by June 15th.
- The e-learning takes approximately 30 minutes.

Alternatives to Restraint Attempted

- ONLY document Alternative (less restrictive) measures for restraints prior to restraint initiation.
  - Explain the specific measure attempted, when it was attempted, and why it didn't work.
  - Add a comment to provide detail instead of relying on the pick list.
- If an Alternative measure is attempted after a patient has been in restraint, and it is unsuccessful, a new restraint order is needed!
  - Alternative measures to restraints are interventions attempted instead of restraints
- Make sure the "Less Restrictive Alternatives tried" in the restraint Order match the "Alternatives to Restraint Attempted" in the Restraint Forms.
  - A new initiation section is needed with matching alternatives

Audit Expectation

- Purpose of audits:
  - Learn by reviewing another chart as a surveyor would
  - Gather data on documentation compliance
- 2 audit tools must be completed by **Friday, July 13th**
  - Restraint Audit (not including FMC and BHU)
  - IPOC/Other Audit
- Audits will **replace** the Nursing Chart Audit tool in June and July
- Completion of Audits
  - Paper copies to take with you today (complete and fax)
  - V-Survey Link will be emailed to you by your manager
- Restraint Audit (not including FMC and BHU)
  - Must audit at least one patient in restraints
    - Audit most recent 3 days
    - If you don't have a restrained patient on your unit, you should audit a patient on a different unit
      - Ask your charge nurse to review the Daily Report (has list of the patients in restraints throughout the entire hospital)
- IPOC/Other Audit
  - Audit a chart of a patient **you are familiar with**

Think of your last shift…

- Think of one patient you cared for in your last shift.
- Assume your practice patient is that patient.
  - You will document in M2Train

Attachment E

Date:__/__/____ Setting:_____ YOUR NAME (Only if Completing on Paper):_____ Entered By:_____
Staff Member_____

Reason for Audit: LEAVE "ENTERED BY" AND "STAFF MEMBER" FIELDS BLANK IF COMPLETING ON PAPER.

The purpose of this audit is to determine compliance with IPOC Documentation.

Instructions: Each nurse should review one chart of a patient on your unit that is familiar.

If you notice any documentation gaps, please communicate the gaps to the nurse or your manager.

Fax paper audits to Diane Johnson (8181). Questions? Contact Cara Nissen (caraniss@sarmc.org)

** Indicates that an answer is required.*

IPOC/Other Audit 2012 (June and July)

Information	Answer	Comments
1.Are you completing this audit on paper? If so, did you clearly write: 1) Your name 2) Setting (unit) the patient is on (if completing audit online, indicate NA)	Yes | No | NA	
2.* Is your unit/department the same as the unit that the patient is/was on? If not, enter YOUR unit in this comment box (includes CST). Enter the setting that the patient is/was on under Setting. If the patient was on more than one unit, enter the last unit the patient was on.	Yes | No	*YOUR UNIT*
3.What is the patient's FIN#?	Yes | No | NA	*FIN #*
4.What are the dates you are auditing? (Last 3 days of documentation for Restraint audit and Admission to present for IPOC/Other Audit)	Yes | No | NA	
IPOC	**Answer**	**Comments**
5.* Review the IPOCs present on the patient's chart. Are there at least 2 subphases initiated? (will be bolded)	Yes | No	
6.Are the selected IPOCs appropriate for the patient, and cover the most important issues for that patient?	Yes | No | NA	
7.Have all IPOCs for resolved or irrelevant issues been discontinued?	Yes | No | NA	
8.Click on each subphase to view the details. Are all of the Outcomes (bullseye icon) and indicators (graph icon) appropriate for the patient? (graph icon)	Yes | No | NA	
9.Click on each subphase...are interventions selected for each IPOC subphase?	Yes | No | NA	
10.Are all of the interventions pertinent to the patient's care at this time?	Yes | No | NA	
11.Is there at least one IPOC subphase that includes individualized interventions? (Comments or Communication Orders added)	Yes | No | NA	
12.Click on "Suggested Plans" in the Orders Menu. Have all IPOC Suggested Plans been initiated? (i.e. Falls, Risk of Injury)	Yes | No | NA	
13.Go to the Document in Plan tab. Has the Outcome status been documented every shift? Click on plus signs next to Outcomes (bullseye icons)	Yes | No | NA	
14.Has an outcome note been added to at least half of the Outcome Scores (red X or green checkmarks)? (Click on each score or look for triangle icons)	Yes | No | NA	

15.Have all indicators with Retrieval Icons been scored? (When you click on icon, it allows selection of "within reference range" or "not within reference range." There will be a red X or a green checkmark if the indicator was scored.	Yes | No | NA	
Other Documentation Questions	**Answer**	**Comments**
16.Review the last 3 days: In Forms Review, has a Handoff Form been completed with every shift change? (if not, indicate the missing dates/times)	Yes | No | NA	*MISSING DATES/TIMES*
17.In the last 3 days, does the "Anticipated Events" section include all important events, tips and tricks, interpreter/blue phone use, and expected events that you are aware of for the patient? (View the last Handoff Form completed to see all of the documentation in the top section)	Yes | No | NA	*IF NOT, WHAT IS MISSING?*
18.Have Handoff forms for the past 3 days been signed off by the oncoming nurse during shift changes?	Yes | No | NA	*IF NOT, WHAT TIME WAS IT DOCUMENTED?*
19.Is appropriate ambulation and/or turning documented for the patient? (should include turns for patients on bedrest, trips to bathroom and in hall until independent)	Yes | No | NA	*IF NOT, MISSING DATES/SHIFTS:*
20.Under Personal Care (in IView Interventions), is a bath/shower appropriate for the patient documented daily for the past 3 days?	Yes | No | NA	*IF NOT, MISSING DATES/TIMES:*
21.Are there any Pain Interventions documented in IView? (i.e. positioning, ice) (if patient does not have pain, indicate NA)	Yes | No | NA	
22.* Is oral care documented according to policy? (BID or every 2-4 hours for unconscious, debilitated, or intubated patients)	Yes | No	*IF NOT, MISSING DATES/SHIFTS:*
23.Review IView Interventions (past 3 days). Are all meals documented (or refused)?	Yes | No | NA	*IF NOT, MISSING DATES/TIMES:*
Advance Directives	**Answer**	**Comments**
24.Do you know where the end-of-life Resource Box is located on your unit? (if you are unsure, ask your manager). CST and non-applicable specialty units may mark NA)	Yes | No | NA	*WHERE?*
25.Can you list 3 items found in the End of Life box on your unit? (if applicable):	Yes | No | NA	*ITEMS:*
26.Do you know who you can call to restock the End of Life Resource Box?	Yes | No | NA	*WHO DO YOU CALL?*
27.Do you know that End of Life Resources are available for patients other than on the Palliative Care service?	Yes | No | NA	
28.Do you know that a "Comfort Care" order set in PowerChart can be used for patients transitioning to comfort measures that addresses the most common end of life comfort needs?	Yes | No | NA	
29.Check the Essential Admission Form in Forms Review. Was the patient asked if they had Advance Directives on admission?	Yes | No | NA	
30.If the patient stated they had an Advance Directive, is there a copy on either the hard chart or in Notes Review?	Yes | No | NA	
31.If family was asked to bring in the Advance Directive, was there follow up to ensure that this happened?	Yes | No | NA	

Attachment F

CRM/MSW Department Documentation Standards/Expectations

* Remember defensive charting; "if it not documented it was not done"
*Individuals may choose to use the headers in their case manangement/social work progress note and then document necessary elements

Initial Assessment/Plan:

- Age
- Diagnosis and circumstances that brought patient to the hospital
- Living situation
- Employment
- Insurance/financial status
- Specific patient needs based upon patient's behaviors/physical and cognitive ability to care for self
- Family support (document specifics i.e. who); degree of involvement and their ability to care for patient. (When talking to family members be sure to follow HIPAA guidelines, use quotes as appropriate)
- Initial discharge plan: likely post discharge needs and why

Reassessment/re-evaluation:

- Summarize any changes including responses to treatment and/or barriers to discharge
- Recognize consultations: Nutrition, PT/OT, etc include patient behaviors and progress/responses to treatment
- Revise discharge plan if appropriate and document why revision is made
- Rounds discussion documentation: identify rounds (i.e. Hospitalist, ICU)what was discussed and share with patient/family
- Staffing w/interdisciplinary team members: what was discussed and share with patient

Implementation/Coordination of Care:

- Services/referrals set up, contacts, phone numbers, time frames & why service needed
- Family involvement
- Insurance coverage/benefits if applicable
- Patient Choice: documentation that list provided of appropriate resources (patient choice form)

Final DC Plan:

- Document finalized DC plan including where patient is going (including specifics), in whose care and their ability to provide care, and patient's behaviors/ability to care for self either partially or completely.

Original: 5-15-12

Attachment G

CRM/MSW DISCHARGE PLANNING AUDIT TOOL

FIN#	Room #	Admit Date	Initial assessment needs identified? Yes / No
Pt Name		Review Date	Age ☐ ☐
			Diagnosis ☐ ☐
CRM	Social work referral? ☐ Yes ☐ No	Social Worker	Home location ☐ ☐
			Financial/Insurance ☐ ☐
			Other ☐ ☐

Mark a C= CRM or a S = SW for the appropriate person who documented the following.
If NO, identify areas of concern in Feedback section
Follow patient through out the patient's stay. Check a few different dates for documentation, plan, reassessment and changes in patient/patient needs.

1. IPOC initiated/updated?	Yes	No								
2. Is there an initial &ongoing assessment in Power Chart that identifies specific patient DC needs involvement of Pt/family? Are the following items addressed and documented in the initial assessment?	○ Living situation ○ Homeless ○ Transportation ○ Clinical Concerns ○ Safety Concerns		○ Lack of financial resources ○ Family requesting assistance ○ Need for Community assistance		○ Psychosocial issues ○ Support System issues ○ Ability to Perform ADL's ○ Ability of family to provide care					
	Initial Assessment		Reassessment documented		Reassessment documented		Reassessment documented		Reassessment documented	
	Date		Date		Date		Date		Date	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3. Does the CM assessment delineate a plan of care specific to the pt's needs?										
4. Need for DME contains details and contact info and patient choice form documented										
5. Need for HH or hospice contains details and contact info and patient choice form documented										
6. Discharge to another level of care contains details and contact info and patient choice form documented										
7. Final DC plan i.e. where patient is going (including specifics), in whose care & their ability to provide care, & patient's behaviors/ability to care for self either partially or completed.										
8. Coordination of Care Documentation of patient's specific DC needs assessments and/or recommendations by various disciplines: PT, OT, Speech, RT, Nrsg, CM, SW, Designate discipline(s) in comment section to the right):										
9. Are disciplinary rounds summarized; (what was discussed) plan changes, needs, including documentation that it was shared with patient										
10. Ordered CRM/MSW consults are completed or discontinued										

Was an Interqual medical necessity review done?	□ Y □ N	

FEEDBACK

Indicator #	Assessment Date	Comments
Reviewer		Follow-up Contact With CRM

Rev 9/28/07sb; 10/1/07sb; 10/8/07sb; 10/15/08sb, 12/6/07sb 6-09jc 11-10pt,2-11jc, 5-12jc

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IDDK97	A. BUILDING _____ B. WING _____	C 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTEI	1055 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation survey of your hospital. The surveyors conducting the investigation were: Gary Guiles RN, HFS, Team Leader Rebecca Lara RN, BA, HFS	B 000	Please see enclosed plan of correction.	
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending	BB283	RECEIVED JUN 18 2012 FACILITY STANDARDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BB283	Continued From page 1 physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88) iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90) ii. Name and relationship of requestee; and (3-1-90)	BB283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IDDK97	A. BUILDING _____ B. WING _____	C 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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BB283	Continued From page 2 iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Refer to federal tags A431, A449, and A450 as they relate to the failure of the facility to ensure patients' medical records 1) accurately and effectively described services provided to patients and patients' response to those services and 2) were complete.	BB283		
BB461	16.03.14.470.08 Discharge Planning 08. Discharge Planning. Consideration for continued care and services in the community after discharge, placement alternatives, and utilization of community resources shall be initiated on admission and carried out to ensure that each patient has a documented plan for continuing care that meets his individual needs. Provision shall be made for exchange of appropriate information with outside resources. (10-14-88) This Rule is not met as evidenced by: Refer to federal tags A799, A806, A808, A809, A818, and A821, as they relate to the failure of the hospital to ensure patients were evaluated for discharge planning needs and a discharge plan was developed and implemented to meet those needs.	BB461		

State Survey Plan of Correction
Saint Alphonsus Regional Medical Center
Complaint Survey Concluded May 1, 2012

Tag	Plan of Correction	Completion Date
BB283 Record Content Federal Tag A431	Please refer to Federal tag A431.	
Federal Tag A449	Please refer to Federal tag A449.	
Federal Tag A450	Please refer to Federal tag A450.	
BB461 Discharge Planning Federal Tag A799	Please refer to Federal tag A799.	
Federal Tag A806	Please refer to Federal tag A806.	
Federal Tag A808	Please refer to Federal tag A808.	
Federal Tag A809	Please refer to Federal tag A809.	
Federal Tag A818	Please refer to Federal tag A817.	
Federal Tag A821	Please refer to Federal tag A450.	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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June 27, 2012

Sally Jeffcoat, Administrator
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

Provider #130007

Dear Ms. Jeffcoat:

On **May 1, 2012**, a complaint survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005440

Allegation #1: Patients were inappropriately restrained.

Findings #1: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records, of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

Five of the six medical records that were reviewed (including the record of a 74 year old male admitted on 3/12/12) contained inadequate documentation to support the use of restraints. Problems identified related to restraints included:

1. Comprehensive assessments indicating the need for restraints were not was performed, including documentation that less restrictive interventions had been tried and were determined to be ineffective.

2. The use of physical restraints was not incorporated into patients' plans of care.

3. Physician orders were not consistently obtained and when restraints were utilized.

4. Restraints were not discontinued at the earliest possible time.

5. The behavior which led to the use of restraints was not documented.

6. The symptoms that warranted the use of the restraints was not documented.

7. Patients' response to restraints and the rationale for their continued use was not documented.

The complaint was substantiated and deficiencies were cited at 42 CFR Part 482.13.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: Patients were not informed of their condition and other information pertinent to their care.

Findings #2: An unannounced vist was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records, of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievences were reviewed.

Five current patients were interviewed on the medical unit on 4/30/12. All five stated they were well informed about their condition and the care they received. Documentation of communication between nurses and patients or family members was incomplete, however.

One medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. Physician and social service progress notes documented the patient's power of attorney (POA) was kept informed of his medical condition and discharge planning efforts.

Nursing progress notes did not document that his POA was informed of his condition, however. For example, Incident reports documented he experienced falls on 3/26/12 and 3/28/12. No documentation was present in the medical record which described the falls or stated that the POA or physician were notified of the events. Restraint forms documented the patient was restrained on 3/18/12 from 1:00 AM until 10:15 AM. No documentation was present in the medical record stating the patient's POA was informed of this event. Restraint forms documented the patient was restrained on 3/27/12 at 4:00 PM until 3/30/12 at 12:00 PM. No documentation was present in the medical record stating the patient's POA was informed of this event.

The medical records were reviewed with hospital staff through out the survey. The electronic

medical record made it difficult to tell whether the problem was with the actual communication or whether the communication was not documented because of structural problems with the record.

Since the electronic medical record impeded the documentation of communication with the patient and his/her family, deficiencies were cited at 42 CFR Part 482.24, Condition of Participation for Medical Records.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: Patients were over medicated which caused symptoms such as sleeping much of the time and interfering with their ability to walk.

Findings #3: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

None of the medical records reviewed contained documentation that indicated patients were sedated for long periods of time except for patients who were chemically restrained while on ventilators.

Patients commonly experience some short term sedation as staff titrate medications which treat the causes of behaviors. In addition, patients with behavioral problems often become exhausted from those behaviors, which can appear as over sedation. This can interfere with their ability to ambulate and to perform activities of daily living. The medical records of patients who did experience declines in their ability to perform certain tasks were provided with therapy to increase their level of independence.

All of the medical records reviewed documented that orders for sedating medications were changed in response to patients' changing condition and family requests. All of the medical records reviewed documented staff responded to patients' changing condition. Therefore, the allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Care ordered by some physicians conflicted with care by other physicians.

Findings #4: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were

reviewed.

None of the medical records reviewed contained documentation that care provided by one physician was contraindicated by another physician. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. A physician progress note, dated 3/30/12 at 3:15 PM, stated the patient was unable to void. The note stated he was catheterized when his bladder scan showed his bladder contained over 900 milliliters (approximately one quart) of urine. The patient was catheterized nine times between 4/03/12 and 4/08/12. A physician progress note, dated 4/06/12 at 12:23 PM, stated a urologist had seen the patient six weeks earlier and did not feel catheterization was warranted at that time. However, that was prior to the patient retaining large amounts of urine. The patient's urinary symptoms resolved after 4/08/12 and he had not been catheterized since.

Urinary retention in large quantities is a medical emergency. Physicians responded to the patient's needs. No deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Patients were not treated for pain.

Findings #5: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

None of the medical records reviewed contained documentation that patients experienced severe pain. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. Pain was measured at the hospital on a scale of 0-10. The patient's medical record contained documentation of his pain level on a daily basis. Between 4/10/12 and 4/19/12, his pain was documented as zero except for 4/12/12 and 4/19/12 when it was documented as two of ten.

The cases which were reviewed did not contain evidence that the patients experienced significant pain.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Patients with urinary tract infections were not treated in a timely manner.

Findings #6: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff

were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

Only one medical record which was reviewed documented a patient with a urinary tract infection. This patient was a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. Laboratory tests initiated on 3/12/12 and on 3/28/12 showed no evidence of urinary tract infection. He developed urinary symptoms on 4/12/12 and laboratory tests at that time did confirm a urinary tract infection. He was treated with two antibiotics beginning on 4/13/12. The urinary tract infection resolved. Urinary tract infections were not noted for the other patients whose records were reviewed.

No evidence of untreated urinary tract infections was found.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The hospital did not provide adequate discharge planning services.

Findings #7: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

Three of the six medical records did not contain documentation of adequate discharge planning. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. While the record contained multiple social service notes addressing discharge planning, a discharge planning evaluation had not been completed and a formal discharge plan was not documented.

Two medical records did not document where the patient was discharged to nor did they document whose care they were discharged to. These records also did not contain documented discharge planning evaluations or discharge plans.

Hospital policies did not specify how discharge planning needs should be assessed and documented. The policies also did not state how discharge plans should be documented.

The hospital had not developed systems which provided direction to staff in order to ensure a consistent approach to discharge planning had been implemented. Federal deficiencies related to discharge planning were cited at 42 CFR Part 482.43 and state deficiencies were cited at IDAPA 16.03.14200.04.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #8: Patients were not assisted with meals.

Findings #8: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

While assistance with meals was not documented, food intake was documented in all records reviewed. No unusual weight loss patterns were identified. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. He had diagnoses of dementia and psychoses. His admission weight was 147 pounds on 3/12/12. His documented meal intake ranged from 25% to 100%. His weight increased initially to 149 pounds on 3/17/12, which may have been due in part to water retention. His weight dipped to 143 pounds on 3/19/12 and then rose again. He weighed 153 pounds on 4/25/12, six pounds more than when he entered the hospital. This did not appear to be water retention as his ankles were not swollen upon observation.

The above patient was observed eating lunch on 4/25/12. Staff set up his tray assisting with things like opening containers. He was observed feeding himself.

Patients who were interviewed stated staff assisted them when needed including meal assistance.

No nutritional problems were identified. The allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: Patients did not receive needed tests.

Findings #9: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

All of the medical records reviewed documented laboratory, radiological, and other testing was provided as ordered. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. He received a computed tomography (CT) exam of his head on admission. He also receivied various laboratory tests including blood counts, blood chemistry, urine analysis, and urine cultures. All ordered tests were completed.

The patient received three visits by a neurologist, on 3/26/12, 3/31/12, and 4/14/12. All of the recommendations by the neurologist were acted upon.

Patients received laboratory, radiology, and other testing as ordered. The allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm